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PENITENTIARY MEDICAL SERVICES

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PREFACE

The development of medical services in the federal correctional system in Canada spans nearly a century and a half, commencing with the opening of the Kingston Penitentiary in 1835. During this period health care has always had an essential role in penitentiary operations. The story of its complex but sometimes stormy evolution reveals not only much about the history of Canadian penitentiaries, but a s f th ntry itself and of the history of medicine.

This report is divided chronologically into five parts. The first part covers the pre-Confederation period. It examines the early decades of the Kingston Penitentiary, an institution which, still in use, is the cornerstone of today's federal correctional system. The second part, looking at the period from 1867-1915, examines the changes during this first period of growth of the federal corrections system. The third period, from 1915-1938, studies developments between the two World Wars and the penitentiary conditions which prompted the wide-ranging reforms recommended in the report of the Archambault Royal Commission in 1983. The fourth period, from 1938-1970, examines the federal correctional system in the era after the landmark Archambault report. The fifth and final part, dealing with the period from 1970-1983, surveys the present era of health care services in the Correctional Service of Canada.

Part One, 1835-1866:

Chapter One

The Founding Of The Kingston Penitentiary

> It is somewhat singular that the most prominent object the spectator sees in approaching or entering nearly every city with which we are acquainted is its prison--as if it were a monitor put to warn the visitor against any breach of those laws, under the security of which he was moving about and enjoying himself. So it is with Kingston, on entering the bay from the westward--the Provincial Penitentiary is the principal object of interest. A large and apparently secure place it is. Horribly dismal to look at, and much more so to think of. In spite of all exertions to render this system of punishment as complete as can be, at considerable expense, statesmen are fast losing confidence in it. It is not found to be productive of that amount of moral reform which was anticipated, and daily experience shows that the confirmed offender gains no good, while the novice in crime runs a great risk of being confirmed in his evil course. In the meantime it is the only effective institution for long-continued personal restraint in the country, and is generally well filled.[1]

Although current ideas about crime and punishment are radically different than those of the 1850s, the physical view seen by this long-ago traveller remains largely unchanged today. The Kingston Penitentiary continues to fulfill its function as an institution for "long-continued personal restraint," and is the oldest institution in the Correctional Service of Canada. Not surprisingly, one must first look back to the pre-Confederation years of the "Provincial Penitentiary" at Kingston in order to understand adequately the historical development of medical services in the federal corrections system. This institution stands out as the preeminent Canadian example of an era of prison construction which took place in Europe and North America in the early nineteenth century. It was now the mind of the convict, not his body, which was being punished. And for at least seventy-five years after Confederation in 1867 this institution served as the model for other Canadian penitentiaries to follow. Its design was copied in every maximum security institution built between then and 1952, apart from the Prison for Women opened at Kingston, Ontario in 1934. Each had a stone wall about thirty feet high, interrupted only by observation towers

with armed guards. The buildings inside the compound had a central dome with cruciform type wings and ranges of iron-barred cells.[2]

The Kingston Penitentiary was founded in response to the need by the Province of Upper Canada for a viable solution to the vexing social problem of crime and punishment. This serious difficulty was reflected in the evident inadequacies of its District gaols. At the heart, however, of this problem was the English Criminal Code, which had always been closely followed since its introduction at the time the Province was founded in 1792.[3] The ritual punishments of the so-called 'bloody code', with public execution for capital crimes and pillorying and scourging for lesser offences, were meant to be shaming and coercive punishments. They would deter potential criminals by the terror of example.[4] As J.M. Beattie notes,

> By the end of the eighteenth century, indeed, some two hundred crimes--most of them varieties of property offences--were subject to hanging and the great umbrella of terror that the criminal code created allowed those who administered it and the gentlemen of England in whose interests and on whose behalf it was mainly run to select victims for periodic demonstrations of the power and the majesty of the law. Not everyone convicted of a capital offence could be hanged, for the blood bath would have undermined public acceptance of the law. Selection of victims was essential, and around the discretion of judges and juries and the royal prerogative of pardon there developed in the course of the eighteenth century an elaborate system which saved large numbers from the gallows--those convicted of relatively minor crimes, those who could bring testimony to their good character, those who could enlist the support of the rich and powerful--and left the worst offenders and the friendless to be hanged as examples.[5]

The implementation of this 'bloody code' was not easily carried out in the pioneer society of Upper Canada. An early problem was the lack of gaol facilities in the newer Districts of the Province; on the other hand, however, there is evidence that crime was not a major problem until the population increased and cities and towns were built up. To avoid overcrowding judges mainly sentenced non-capital offenders to fines, corporal punishment, pillorying, and banishment as alternatives to imprisonment. Furthermore, most of the early gaols were crude, make-shift structures. They did not separate prisoners by age

or sex, were deficient in cleanliness, and were lax in discipline.[6] In 1831 the Legislative Committee studying the erection of a penitentiary claimed that the gaols were "seminaries kept at the public expense for the purpose of instructing his majesty's subjects in vice and immorality, and for the propaganda and increase of crime."[7]

Pressure for reform also came from changing attitudes towards crime and punishment in England. The 'bloody code' had been under attack there since the 1760's. The reformers who were spurred by either humanitarian or utilitarian considerations were inclined to have the common objective of reducing the scope of capital punishment. These critics believed the wide use of the death sentence was more ineffective than it was inhumane. It was argued that the judicial system was being undermined because minor offenders risked the gallows, consequently leaving victims refusing to prosecute and juries refusing to convict. Instead, moderate punishments to fit the crime were urged which would both punish and reform offenders. Imprisonment but without the wanton and unhealthy conditions of the old gaols came to be seen as suited to the twin task of punishment and reformation. By the 1820s this new doctrine had made for great changes in the law and the penal system.[8] Not surprisingly, the need to reform the prison system in England eventually affected the law and the prisons of the colony. In addition to the rhetoric of reformers influencing English law, thus indirectly affecting the law of the colony, by the 1830s the Colonial Office was pressuring the provincial Government to ameliorate the squalid conditions of the District gaols. For years these conditions had been routinely condemned by many grand juries.[9]

The English experience of a strong reluctance to resort to capital punishment except for murder came to be duplicated in Upper Canada. By the 1830s juries there were averse to guilty verdicts, a situation legislators found to amount to an amnesty for all minor offences. In 1833 the law was eased to eliminate capital punishment for a large number of crimes. Only twelve capital

offences remained instead of dozens, with the list now including murder, rape, robbery, burglary, and arson. This revision had followed a similar British Act in 1827. After 1841 only the crimes of murder and treason led to the gallows.[10] Corporal punishments also came under attack from legislators for being "improper" and "degrading." Likewise, fines, imprisonment, and banishment now had their weaknesses. The first was "unjust" because the financial resources of transgressors differed. Secondly, imprisonment was "inexpedient and pernicious in the extreme" on account of the lack of segregation of different types of prisoners. Clearly, holding all types of prisoners in undifferentiated captivity was no longer acceptable. And, thirdly, banishment inclined to be ineffective.[11] A new society of strangers had replaced one of ranks and orders, a change which gradually dictated changes in the law if it was to remain an effectual deterrent to crime. No longer could a 'bloody code' of justice make a criminal feel shamed in the face of his neighbours or well-known for his crime.[12]

With this profound change in the law of the province a measure of reform was required for the existing system of punishment. The apparent answer for the provincial legislators was to construct a penitentiary. As Rainer Baehre points out, "The catalyst to change proved to be the dramatic increase in population, especially in the Home District [i.e. the Toronto area], in the years 1827-1835."[13] The rapidity of the growth in population can be seen in the fact that between 1815 and 1840 this figure soared five-fold, from 80,000 to over 400,000.[14] By deciding in 1832 on its construction the Government of the province was following a method of penal reform initiated in the United States in the 1820s. David Rothman has aptly called this innovation "the invention of the penitentiary."[15] In both Upper Canada and its southern neighbour the penitentiary was to some degree the product of a general view that society had become disordered:

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> Convinced that deviancy was primarily the result of the corruptions pervading the community, and that organizations like the family and church were not counter-balancing them, they believed that a setting which removed the offender from all temptations and substituted a steady and regular regimen would reform him. Since the convict was not inherently depraved, but the victim of an upbringing that had failed to provide protection against the vices at loose in society, a well-ordered institution could successfully re-educate and rehabilitate him. The penitentiary, free of corruptions and dedicated to the proper training of the inmate, would inculcate the discipline that negligent parents, evil companions, taverns, houses of prostitution, theatres, and gambling halls had destroyed. Just as the criminal's environment had led him into crime, the institutional environment would lead him out of it.[16]

In order to implement these behaviouralist aims the promoters of the Kingston Penitentiary adopted the congregate system of prison discipline developed at the Auburn Penitentiary in New York State in the early 1820s. Convicts laboured together in silent association during the day under contract to outsiders and spent the night in solitary confinement. And, to aid in the reform of the convict instruction was provided in morals and religion. Silence and hard labour were strengths of the system, enforced by a strict regimen which often made use of the lash.[17] And of these two mechanisms, hard labour was to be the major instrument for the ultimate reformation of the convict. As work was the highest value in the nineteenth century, so then was it regarded as the best punishment. It would serve a two-fold purpose. Besides training the inmate for profitable employment on his return to the community, it would alter his character and teach him the mores of a society which valued work so highly. And, not unimportantly, the labour of the prisoners would financially aid the economy of the prison. This would be done through having them build these institutions, having them manufacture goods or perform services for internal use, and through hiring out their labour to outside contractors.[18]

An integral part of the congregate system was the set of rules and regulations which governed the prison staff and the convicts. As J.M. Beattie

points out, the code of discipline aimed at making the whole life of the convict one of "labour, silence, and strict obedience."[19] "The point clearly was to impose regularity of labour and good work on men who were assumed to have been lazy and idle, while at the same time isolating each man, breaking his spirit, taming his passions and preventing the kind of corruption that indiscriminate intercourse among the prisoners was thought to encourage."[20] In addition to aiding the smooth functioning of the prison, regulating, for example, the lockstep marching of convicts to and from the cells, the rules imposed on convicts underlined their abject submission to the prison authorities. A psychological punishment was to be given to the convict that was "so terrible that the dread of a repetition of it deters him from crime, or [by] his description of it, others."[21] Nonetheless the central goal was the moral reform of the convict. It was to be achieved by completely removing him from his previously iniquitous environment and imposing on him a servile routine of hard labour. Crime was seen as rooted in immorality and the institution was to serve to purify the morals of the convict.[22]

But, importantly, the moral reform of the convict was impossible if his health declined steeply upon entering the prison. The logic of reform thus dictated that a similar emphasis on purification apply to the health of convicts. Moreover, the wanton and unhealthy life of prisoners in the common gaols and prisons (conditions which genuinely shocked prison reformers) had to be eliminated if long-term detention was to be publicly accepted as a humane method of punishment. And the confined, too, had to be convinced of its moral legitimacy.[23] If prisoners were to work continually at hard labour they had to be kept in good health. The spread of infectious diseases also had to be controlled, both inside and to or from outside the prison, if mass confinement was to succeed. In this respect, the health of the outside community was kept in mind by prison reformers, at least in England. Occasionally, disease had spread

outside the walls of English prisons, as in 1750 when two prisoners ill with typhus or gaol fever infected the Old Bailey courtroom in London where they were standing trial. The contagion then carried off at least fifty people, including among them the judge, the jury, and lawyers and spectators.[24] Indeed, it was asserted by the English prison reformer John Howard that more prisoners died by gaol fever then by the hangman's noose in the English prisons he visited in the late eighteenth century.[25]

In the penitentiary the health of the convict's body therefore had to be regulated because it was important to the health of his soul. Proper hygiene was necessary if the ultimate aims of the institution were to be met--the punishment, deterrence and reform of criminal behaviour.[26] Nonetheless the Kingston Penitentiary soon proved to have difficulty fulfilling these key aims, despite the buoyant hopes of its promoters. By 1841 the rate of recidivism was embarrassing. Close to one-quarter of the former prison population had been returned there at least once.[27] Obviously the moral reformation of the convict was not to be easily accomplished. The same can be said for the smooth administration of the penitentiary. By 1847 it was evident to the public that affairs there were very amiss, with the provincial newspapers discussing alleged irregularities. Stories of cruelty to convicts led to strong pressure for a government inquiry. Moreover, the refusal of the prison doctor in June 1848 to attend to his duties until a full investigation was held into the institution's operation signalled the final administrative breakdown. The subsequent Commission of Inquiry in 1848-49 resulted in the dismissal of the Warden and the faction of staff who supported him.[28]

Some changes were made in the prison discipline as a result of this investigation, but the congregate or Auburn system largely remained in place until the early 1930's. What did change significantly throughout the early decades of the penitentiary was its character as officials there gained first-hand experience in its management. This gradual evolution can especially

seen in the delivery of medical services. The role of the prison doctor and his staff, the availability of proper hospital facilities, the prevention and control of contagions in the institution, and the treatment of insane convicts were important factors there in the pre-Confederation decades. And, importantly, each of them were integrally subordinate to the preservation of the rigid discipline of the penitentiary.

Chapter Two

The Medical Staff

The primary basis of the new emphasis on convict health care was the prison doctor. During the eighteenth century medical practitioners had, judging from gaol conditions in England, usually encountered prisoners only if the threat of gaol fever spreading to the outside community was thought to be serious or, perversely, as subjects for dissection by medical students.[1] The permanency of the doctor's place in the hierarchy of the penitentiary was signalled by the same legislation which sanctioned the creation and regulated the operation of these institutions. Such laws helped to create a new breed of prison staff who would be conversant with and inured to the penitentiary culture that did not yet exist.[2] One of the first of these statutes was the English Penitentiary Act of 1779. By this law the Justices of the Peace of each County were obligated to appoint to each of the local prisons they were responsible for an experienced surgeon or apothecary. He was then duty-bound to visit the gaol, attend to the sick, and if necessary, put any seriously ill prisoners in the prison infirmary, a facility required under the terms of the Act.[3] John Howard, one of the formulators of this Act and the leading prison reformer of his age, emphasized the importance of the prison doctor.

> The late act for preferving the health of prifoners (1779) requires that an experienced Surgeon or Apothecary be appointed to every gaol: a man of repute in his profeffion. His business is, in the firft place, to order the immediate removal of the ſick, to the infirmary: and fee that they have proper bedding and attendance. Their irons fhould be taken off; and they fhould have, not only medicines, but alfo diet suitable to their condition. He must diligently and daily visit them himfelf; not leaving them to journeymen and apprentices. He fhould constantly inculcate the neceffity of cleanliness and fresh air; and the danger of crowding prifoners together; and he fhould recommend, what he cannot enforce.[4]

James Sampson, from 1835 to 1861 the first medical officer to the Kingston Penitentiary, provides an excellent example of such a Canadian prison doctor in this new era. Originally a military surgeon from Ireland, Dr. Sampson was dispatched to Canada just prior to the War of 1812. After the war's end he eventually settled in Kingston, where from 1820 until his death in 1861 he was a very prominent local doctor, a Professor of Medicine at Queen's College from 1854 on, and also at times a leading municipal politician. As well he was active on the provincial medical scene, serving as a member of the Medical Board of Upper Canada (which licensed physicians) from 1822 until his death.[5]

As an officer of the penitentiary Dr. Sampson closely worked with and was directly responsible to the Warden, who in turn answered to a Board of Inspectors appointed by the Government. His duties were set down by statute and also by the Board of Inspectors, who by law had been given the power to make all necessary rules and regulations respecting the administration of the institution.[6] By law it was the duty of the prison doctor, as prescribed in an 1834 Act governing the maintenance and discipline of the prison,

> ...to keep a register of all sick convicts placed under his care, stating the disease with which they were or are afflicted, and the date of their entering and leaving the Hospital: also a register of the deceased convicts, stating their names, ages, times and causes of death, and all other circumstances which he may deem necessary; which register shall always remain at the Penitentiary and be open for inspection.[7]

It remained for the Board of Inspectors to give more precise guidance to the prison doctor about his duties. In drawing up rules and regulations in 1835 and 1836 for the prison doctor the Inspectors relied almost verbatim on those in force in 1835 at the Connecticut State prison. This institution and other prisons in the United States had been toured in 1835 by Charles Duncombe, a Reformer and an active promoter of the Kingston Penitentiary.[8] The physician was thus required to visit the institution at a specific time daily, to examine all

the sick and complaining convicts there, and to prescribe treatment such as these cases required. His visits were to be repeated throughout the day when the condition of the sick necessitated it. Dr. Sampson was also obligated, when sent for by the Warden, "to repair immediately to the Prison, to the exclusion of all other engagements."[9]

Once ill convicts had been discharged from the hospital or their cells as recovered, and were able to work at hard labour in the prison shops or outdoors, the prison doctor had to record the time of their discharge and then report this information to the Warden. Any discharge because of death of course also had to be reported to the Warden, who in turn would notify the Board of Inspectors at their next meeting. The body was to be interred at the earliest possible moment, with the Surgeon having conducted an autopsy if he deemed the circumstances of the death required it. Dr. Sampson was also charged with a number of minor duties. Each year he had to submit a report which would be included in the yearly report of the Board of Inspectors to the Government on the state of affairs at the penitentiary. In these reports reference is made to the execution of his duties and to the general health of the convicts, touching upon such topics as the general mortality of convicts, the prevalence of contagious epidemics, and the treatment of insane convicts. Another occasional duty of the prison doctor was to examine the quality of the prison dietary, with a view to suggesting possible changes to the Board of Inspectors in the interest of the preservation of the convicts' health.[10]

For the performance of these part-time duties (likely two hours at most per day) Dr. Sampson was paid L.100 per year from 1835 to 1841, after which his salary was doubled in recognition of the growing prison population. In 1856 it was further raised to L.250 per year, so as to bring it in line with salary increases recently given to all the other officers. By comparison, in 1836 the Warden, Deputy Warden, and Keepers were paid L.200, L.150, and L.80 respectively; by 1856 these salaries had risen to L.560, L.250, and L.140.[11]

Rules and regulations also governed the duties of the Hospital Keeper, without whom the Surgeon's practice at the prison could not have been a part-time one. Originally a convict was employed at this post, supervised by the Keeper of the Hall, but in 1837 this was deemed to be inconsistent with the terms of his sentence. Perhaps this change actually occurred because a suitable convict could not be found for the job, or it may in fact have been an acceptable expedient while the prison had less than a hundred inmates during its first two years of operation.[12] It is worth noting that it was then a common practice in American penitentiaries to appoint a convict as nurse and place him in charge of the prison hospital.[13] After 1837 this practice was continued in an altered form at the Kingston Penitentiary. The convict nurse was now under the direction of the Hospital Keeper and the Surgeon.[14]

Prison keepers were seen by the promoters of the penitentiary as the personal link with the convicts in the administration of the prison.[15] This was certainly true for the position held by the Hospital Keeper. The duties laid out in 1836 for this position illustrate the personal nature of the keeper's job and at the same time reveal much about the daily routine of medical care at the penitentiary. The latter would change little during the rest of the nineteenth century. The Hospital Keeper was responsible for the general overseeing of the hospital, subject to the control of the Surgeon. He had to keep it "well-ventilated, the Clothes and Bedding clean and the walls and floor cleansed and purified by frequent scrubbing and whitewashing." These cleaning duties were probably carried out by convicts under his supervision. The Hospital Keeper was also charged with transmitting orders from the Surgeon to the Warden respecting the diet of hospitalized convicts. These special rations were provided by the Kitchen Keeper for distribution through the Hospital Keeper. Similarly, if a prisoner died in the hospital or in his cell, it was the Hospital Keeper's duty to notify the Surgeon as soon as possible.[16]

The responsibilities of the Hospital Keeper were not limited to the confines of the prison hospital. A chief duty of his was to be present at the morning prison roll call and the dinner and supper meals. If any convicts complained of illness at these times he would, with the aid of a Guard, record their names on the daily Sick List. He was then responsible for seeing that until the visit of the Surgeon they were locked back into their cells, where by law unemployed convicts were supposed to be during the day unless employed at hard labour.[17]

While these rules and regulations reveal much about the duties of the Hospital Keeper, little is known about the men who held this post. Christopher Julian, the first of them, resigned in August 1847 for unknown reasons. He was succeeded by William Jones, who had been a Hospital-Sergeant in the British Army for three years prior to coming to the penitentiary. Because Jones had a large family he lived with them just outside the prison in one of the staff cottages, instead of inside the walls as preferred by the Inspectors.[18] From 1849 onwards free accommodation was provided for the Hospital Keeper, an annual value of L.12.10s. Almost certainly this practice was implemented on the recommendation of the Commission of Inquiry, which recognized that the Hospital Keeper should live near to or in the prison compound, in order that he should "devote his whole time to the duties of his ofice."[19] Jones remained at the prison until 1854 when he was succeeded by Edward Whymann.[20] It is not known why Jones left his post nor is information available about the background of his successor. Whymann apparently held the job until 1868.[21]

The sick and complaining convicts were examined by the Surgeon every morning, except for Sundays when only serious outpatient cases and hospital patients were seen by him.[22] The names of the convicts, together with their afflictions and a description of their treatment, were recorded in the Sick List Diary. Sick convicts could either be continued on the Sick List or discharged

from it. Conversely, convicts complaining of illness could be put on the Sick List or refused admission to it. In this last respect malingering was an almost daily problem for the Surgeon. Moreover, it was clearly seen as a serious threat to the discipline of the penitentiary. Dr. Sampson believed this duplicity by convicts was motivated mostly by the desire to gain a temporary break from hard labour or at least a posting to lighter work. And, to a lesser degree, convicts were reporting themselves as ill to the Hospital Keeper in order to gain a respite from the monotonous silent discipline of the prison. These motivations consequently producted a host of trivial complaints about slight but evident ailments and about totally bogus ones as well.[23] It was therefore incumbent on the Surgeon to do his utmost to prevent the convict from escaping hard labour, "a material item in the sum of his punishment."[24] The medical officer had, in the words of Dr. Sampson,

> ...to be constantly on his guard against deception; which if he did not devize [sic] means to defeat the sick list would swell very inconvenient to the economy, and perhaps dangerous to the discipline of the prison; with this conviction therefore when there is no unequivocal proof of simulation, tho' strong reasons to suspect it the patient is treated with respect to regimen, confinement to his cell and medical exhibition, as assiduously as if there was no reason to doubt his honesty.[25]

Although Dr. Sampson admitted he was not successful in exposing all the malingerers, his diligence was seen to have a marked effect and he was commended for it by the Board of Inspectors.[26] It is notable that a few of the convicts, when asked on their discharge from prison about the quality of medical care, did say malingering was a problem for the doctor. As one convict commented, "If they are really sick the best of care is taken of them, but there is so much scheming the Doctor must be puzzled to know who is really ill."[27] However, some convicts strongly believed that they had been wrongly judged and kept off the Sick List,

either by the Surgeon or the Hospital Keeper. One convict, for example, complained that when ill he was given only one cup of gruel and then sent out to work.[28] Similarly, another convict though the greatest hardship encountered at the prison came "when a man is sick and not attended."[29]

Complaints about the care given by Dr. Sampson were also heard by the Commission of Inquiry in 1848-49. In an attempt to remove the Surgeon from his position Frank Smith, Kitchen Keeper and son of Warden Smith, had laid four charges against him. One of these charges alleged "Improper treatment of, and negligence towards sick Convicts, and behaving with cruelty towards them,"[30] Of the six cases presented to support his charge, only one was deemed worthy of investigation. The others were seen as trivial complaints. In one of the latter the Matron and another female staff member reported that a female convict had died very unexpectedly, after she had said the Surgeon neglected her treatment. But it was easily established that the patient had been seen regularly by the Surgeon or his substitute. Another such case involved a convict who sprained his ankles and thought he had been released from the hospital too soon. Yet it was readily proven the convict was "quite fit to walk" when discharged. It also was apparent to the Commissioners that Dr. Sampson had "taken great pains with the case." The only case they closely examined was a suicide there in 1847. Here the Surgeon was absolved of the charge that he had not seen the convict from the time he reported him insane until his death. It was shown that he had fulfilled his duty by reporting the convict insane, in order for him to be removed to the Provincial Lunatic Asylum since the prison was not equipped for the care of lunatics.[31] Also testifying against Dr. Sampson were prison staff who had heard convicts complain that they were treated badly by the Surgeon. However, the fact these complaints were few and trivial actually put the Surgeon in a favourable light. Furthermore, other prison staff and several Kingston physicians swore that Dr. Sampson treated the convicts well and humanely. The Commissioners

therefore found the charge against Dr. Sampson of improper treatment to be groundless.[32]

In contrast, a generally less positive opinion was held by some convicts respecting the attendance of the several Hospital Keepers. It was said by some that they were not kind enough to the sick, while others were more specific in their negative comments. One convict implied that the Keeper Julian did not always follow the Surgeon's directions.[33] Another charged that he had seen Julian "in an unfit state to administer Medicine and had wanted to give a convict his dose three times over."[34] He was also accused by one convict of having wrongly and harshly judged him: "I was once sick but I was thought to be scheming. Mr. Julian dragged me out of [the hospital?] when I had a blister on me."[35] By comparison William Jones was thought by one convict to be "quick in his temper."[36] Another convict during Jones' tenure said that "he was not well used in Hospital till the Doctor noticed his situation."[37] Edward Whymann also had his share of disapproving convicts. According to one comment the medical attendance had not been good "since the present Keeper came, thinks he tells the Doctor what is not the truth."[38] Likewise, another grumbled that, "Dr. Sampson is very considerate and attentive but the Hospital Keeper is not a proper person as he is hasty and unkind."[39] Yet these Keepers also had the high respect of some convicts. One convict believed there was good medical care, particularly by Mr. Jones. The convict was in a good position to know for he had been a very sick inmate of the hospital.[40]

Another perspective of the Surgeon and the Hospital Keeper was of course held by the Warden and the Board of Inspectors. As for Doctor Sampson, he was highly regarded by both of these parties, apart for his struggle in 1847-48 with the corrupt regime of Warden Smith and the Board of Inspectors which supported the latter's actions. The Commission of Inquiry, however, completely exonerated Dr. Sampson of all charges of misconduct and at the same time commended him for

his action in calling for a Government inquiry into affairs at the penitentiary. Upon the delivery of this verdict in October 1849 he returned to his post, from which, at his own request, he had been suspended in June 1848.[41] His services continued to be highly valued, despite a disabling fall in 1855 which left him somewhat lame and necessitated periodic leaves of absence until his death in 1861.[42] He was then succeeded by Dr. John R. Dickson, a prominent surgeon and educator who helped found the medical school at Queen's College in Kingston. Dickson held this position until October 1872.[43]

As for the Hospital Keepers, the evidence indicates that only Jones and Whymann came under any censure. D.AE. Macdonell, who succeeded Henry Smith as Warden, was not altogether satisfied with the attitude of being William Jones. In his Daily Journal he noted for some time his disapproval of this Keeper's attitude of being displeased or either absent when unexpectedly called from his home to attend to sick convicts. Yet it appears that for some reason Jones eventually changed his attitude and restored himself to the Warden's good graces. Perhaps the Warden believed that Jones, benefitting from free housing, was by infrequently being at home abusing a privilege not lightly given.[44] Jones was certainly censured in 1852 when he was informed by the Inspectors, probably on the complaint of the Warden, "that the Convicts Sick in the Hospital should be compelled to maintain perfect silence and not be permitted to talk or to converse with each other."[45] In contrast, Edward Whymann was censured a number of times by the Inspectors. The first occasion was in 1855, when he was reprimanded after the Warden complained that the Hospital Keeper had not taken a sick convict into the hospital as ordered. According to the Warden's Daily Journal he had seen the convict in his cell, during his nightly inspection, and had called the Hospital Keeper to attend to the case. Whymann declined to give the convict any medicine and would not see him, though he had gone earlier.[46] But the harsh demeanour of this man was fully revealed by another episode the next year. In August 1856 the

death of a convict from peritonitis after hospitalization of three days was apparently not found unusual.[47] However, in July 1857 the Inspectors reviewed the circumstances behind this death. The Warden brought before them a Guard who swore the Hospital Keeper had hit the convict in the stomach, leaving him groaning in pain. A convict also witnessed the scene.[48] He graphically recalled the details.

> The Keeper asked the patient where he felt the pain. He pointed to his stomach. The Keeper then said ["]I will damned soon take that pain out of you["] and gave him a pretty severe blow in the stomach...The Keeper ordered Medicine, the Convict appeared to suffer much all night from his groaning. On Dr. Strange [then substituting for Dr. Sampson] seeing the patient he observed to the Keeper that he might have sent for him.[49]

Consequently Whymann was strongly reprimanded by the Inspectors, with a warning to be careful in the future for a similar episode would lead to his dismissal.[50]

From an examination of the roles played by the Hospital Keeper and the Surgeon it can therefore be seen how their jobs fitted integrally into the highly structured daily routine of the Kingston Penitentiary. It is clear that the job of the Hospital Keeper was a very regimented but essential one, with its importance reflected by the eventual provision of free housing for him. Nonetheless it was a somewhat ambiguous position. Besides his medical duties he performed a disciplinary function, ensuring that ill or complaining convicts were properly confined and accounted for in the prison. And, to some degree, he also aided in maintaining the discipline of the prison by turning back some complaining convicts whom he thought were malingerers. As a mediator between the sick and the prison doctor he thus had a measure of arbitrary power, for in the latter's absence he could choose to treat convicts for slight ailments or instead draw them to the immediate attention of the Surgeon. Yet it is quite evident that the power of the Hospital Keeper was kept in check by the Warden, who could

call on him at any time to see convicts and who by his visits to the hospital could exercise a measure of supervision over the former which was beyond that of the Surgeon. If he was seen as not performing his duties he could readily be censured by the Board of Inspectors, as happened a number of times. All considered, it would seem that he was firstly a prison keeper and secondly a medical orderly.

In comparison, the role of the Surgeon was considerably more ambiguous. He was both a healer and disciplinarian, treating genuine cases of illness while turning away those whom he believed to be malingerers. As an officer of the penitentiary he performed his duties according to the general instructions of the statutes governing the prison's operations and to the instructions of the Board of Inspectors. At the same time he was only a part-time officer there, which to some extent put him at arm's length from the daily operation of the institution apart from the provision of health care services. Normally his function as a healer was not incompatible with his function as a disciplinarian. But when administrative controversy broke out at the prison in the late 1840's, precipitating the Commission of Inquiry, these two obligations of the Surgeon conflicted with each other. As a result the Surgeon became a man in the middle. In the end, Dr. Sampson was vindicated, with his personal character and professional reputation unblemished. Yet had the new provincial Government not been so eager to check the abuse of power at the penitentiary and instead ignored the protests of the Surgeon, then the prison doctor might have been replaced by someone else less scrupulous.[51] The episode shows that the prison doctor had a special but potentially insecure place in the prison hierarchy, a disciplinary agent but at the same time a healer whose medical expertise was seen as beyond reproach from other officers of the institution.

The available evidence also indicates that both the Surgeon and the various Hospital Keepers generally performed their duties as directed. Yet they

certainly did not satisfy all the recipients of their care, who as convicts were in a passive position since they could not turn to other doctors if they were dissatisfied about the quality of health care there. As well, convicts were in a suspect position, no doubt deservedly for some, unless their ailments were deemed beyond question to be real. Nevertheless the evidence suggests that health care was an important priority in the operation of the penitentiary. Yet both of these posts carried ambiguous responsibilities. At the same time they tended to the ill health of convicts their loyalty was also owed to preserving the rigid discipline of the prison. Although this situation did not create major problems for the Hospital Keepers, it did for the Surgeon. His position as truly a man in the middle can be fully seen in the events surrounding the Commission of Inquiry in 1848-49.[52] Fortunately for Dr. Sampson, he then proved to be "a man of repute in his profession," exactly as John Howard had thought a prison doctor should be over half a century earlier.

Chapter Three

Living Conditions and Hospital Facilities At The Kingston Penitentiary

To have been a convict during these early years of the history of the Kingston Penitentiary was to live in a somewhat unhealthy environment. The prison was of course designed for the long-term detention of convicts, but its inadequate physical structure and the hard daily routine there did not make it the healthiest place to be. Indeed, the living conditions left much to be desired for decades afterwards. Between the late 1890s and 1914 renovations took place in order to enlarge the tiny and embarrasingly antiquated cells and to provide them with proper sanitary facilities. Also improved were the lighting, and the heating and ventilation of the building.[1]

Much careful thought went into the design of the penitentiary, which when planned in 1832 was to be the largest public building in Upper Canada. With its cruciform plan, dome, and detailed interior arrangements it was, as C.J. Taylor notes, "one of the more advanced prison designs in the world, more sophisticated than the American penitentiary buildings at Auburn and Sing Sing, institutions which inspired its creation. It remained impressive for decades afterward, attracting many visitors and comments in popular journals."[2] Like another public building in Upper Canada, the gigantic permanent Provincial Lunatic Asylum, opened at Toronto in 1850, the penitentiary design was an excellent example of moral architecture. Its plan gave architectural manifestation to particular contemporary views about the proper treatment of prisoners and more general ideas on order and morality. However, it was lacking in the more practical matters of proper heating and ventilation.[3] These aspects of prison design were considered by its promoters, its architects, and its administrators. Particular consideration was given in this regard to the cells occupied by the convicts. These were arranged in parallel cell blocks, each five tiers high, and were

separated from the exterior walls by a space of two feet. Two cell blocks comprised each wing, with inspection avenues for the keepers and guards located between the galleries running along each tier. The cells were long and narrow, originally measuring two and a half feet wide by nine feet long. Their length was amended in 1833 to eight feet four inches long. William Powers, formerly Deputy Keeper of the Auburn Penitentiary, was the Superintending Architect and Deputy Warden of the Kingston Penitentiary. In 1832 he regarded these cells as superior to those at Auburn which measured three and one-half feet by seven feet. He believed his design gave the prisoner more useful space while at the same time the narrowness of the cells allowed for them to be crowded together to facilitate surveillance.[4]

At one end of each cell was a grilled door which opened onto the gallery, while at the other end a small window provided for the circulation of air inward from the outer area between the cell block and the exterior wall.[5] This allowance for ventilation was viewed as extremely flawed by the Commission of Inquiry in 1849. The Commissioners recommended that air should be introduced into the cell blocks since no means was provided for the escape of foul air.[6] As was the case at the Auburn Penitentiary, it was difficult to secure an even circulation of the air.[7] Yet it is likely the problem was not serious, with the foul air found by the Commissioners probably consisting of odors from the bodies of convicts and the tubs of excreta in the cells. Such a condition would be unpleasant but not unhealthy. Nonetheless it is important to note the concern over this issue. The Commissioners may have recommended the ventilation be improved because in its defective state they saw it as a prime breeding ground for diseases to spread throughout the prison. They probably viewed disease, like the majority of people in their era, as spread miasmically by the poisonous effluvium that was supposed to rise from putrid matter, swamps, and decaying

vegetable matter. The free circulation of air in the penitentiary, so as to prevent such deleterious gases from settling there, was thus an important priority. This belief was quite evident during the 1849 cholera epidemic at the penitentiary.[8]

In contrast, the heating of the prison was definitely inadequate. Like the ventilation of the prison, it was difficult to secure an even circulation of heat. Convicts with cells in the lower tiers, particularly the first, found them unpleasantly cold in the winter because the heat rose to the higher tiers.[9] Even a century later, in the 1950s, an inmate found that the prison was poorly ventilated.[10]

While some convicts had to endure the inadequate heating of the prison, all convicts experienced the uncompromising dietary of the institution. By law they were to be supplied with a sufficient quantity of inferior and wholesome food, though at times the actual amount and standard departed from these criteria.[11] In practice, it was a monotonous, bland and starchy diet which was hardly suited to provide enough sustenance for convicts working at hard labour, particularly in quarrying stone or in building construction. Breakfast usually consisted of bread, potatoes, coffee, molasses, and, alternately, salt pork or salt beef or fresh beef for five days a week. Dinner comprised bread, salt pork or salt beef or fresh beef alternately for seven days a week, and potatoes and soup. Supper was the starkest meal, with only porridge and molasses except on Sundays when bread and fresh beef were also served.[12] It was a very similar diet to that at the Auburn Penitentiary.[13]

While each convict must have suffered somewhat from the poor living conditions at the prison and its poor diet, their general health seems to have been adequate. During the period under study the penitentiary officials were quick to point out that the convicts enjoyed good health, apart from such years

when epidemics struck. This was said to be due in part to the good prison living conditions and in part to the effective prison medical care.[14] Indeed, it was claimed, probably with some basis, that the convicts' by virtue of being prevented from lives of dissipation, actually ended up healthier. As Dr. Sampson expounded in his annual report for 1856:

> In looking back at the total list of Convicts received in the Prison since its opening in 1836, I find their number to be Four thousand two hundred and thirty-seven up to the end of the past year; and that the number of deaths during that period has been One hundred and forty-five, which gives a ratio of the latter to the former of about 3 1/2 per cent during twenty one years of various sanitary conditions. Had the same individuals, who have consitituted the number thus condemned to imprisonment, been allowed-by evading the law-to proceed in their unrestrained habits, it is reasonable to believe that the list of mortality amongst them would have exceeded the above proportion and therefore, if such conjecture be justly founded, the superior preservation of life among those thus consigned must be admitted.[15]

There were, of course, convicts who were quite debilitated in health on their admission to the penitentiary. A few were in fact deathly ill. Their debility was thus an occassional theme in the annual reports of the institution, and it was often echoed in the reports of American penitentiaries.[16] In the case of Kingston, this state of poor health was usually attributed to the dissipated or irregular lives which convicts had lived prior to their confinement. On one occasion, though, unhealthy gaol conditions were blamed. In 1855 the Board of Inspectors of the Penitentiary privately complained to the Government about the negligence of District sheriffs in not "immediately conveying Prisoners to the Provincial Penitentiary in accordance with their sentences." In particular, they complained of the prisoners that "very many arrive here in bad health from being confined in filthy and badly ventilated gaols."[17]

It was scarcely an unfounded complaint by the Board of Inspectors. Many of the local gaols in Upper Canada were crude affairs. No doubt similar conditions prevailed in Lower Canada, from which convicts were sent to the penitentiary

after the union of the two provinces in 1841. At Toronto in 1830, for example, the basic diet of the local gaol was bread and water, linen was changed infrequently, and soap was a scarce commodity. Understandably the crowded parts of the gaol were quite nauseating. Medical care was available there, but on at least one occasion, in 1833, the prisoners had complained to a Grand Jury that it was difficult to obtain. Nonetheless the gaol surgeon from 1818 to 1858, Christopher Widmer, called a number of times for the prisoner's diet to be increased. However, these creditable requests were generally evaded by the local magistrates who superintended the gaol, as they evidently preferred to minimize costs. The penitentiary was therefore sometimes left to cope with debilitated convicts arriving there, with a few being in a consumptive state who could not be restored back to health.[18]

It is important to note that generally few convicts died at the prison in any given year. The penitentiary was therefore fulfilling its basic purpose of providing a punitive long-term period of detention, with its regimentation of the bodies of convicts normally undeterred by the pestilence which had intermittently ravaged gaols and prisons in former eras. From the opening of the prison in late 1835 to the end of 1866 there were only nine years in which more than twenty deaths took place; indeed, until 1854 there were only two years, 1847 and 1849, in which more than ten deaths occurred. The worst mortality came in 1864 when forty-two convicts perished, half of them from typhoid fever. From 1860 to the end of 1866 this persistent scourge took fifty-one victims. Other major causes of death were cholera and tuberculosis, which were responsible, respectively, for twenty and seventy-three victims. In all, during this era, a total of 372 convicts died at the penitentiary.[19] More deaths, though, would certainly have been registered there if it had not been the practice to pardon terminally ill convicts who were well-behaved.[20]

Table 1

MEDICAL STATISTICS AT END OF EACH FISCAL YEAR, 1835-1866.*

YEAR	HOSPITAL CASES	OUTPATIENT CASES	TOTAL	DIED	PRISON POP.
1836	21	484	505	1	81
1837	16	726	742	1	123
1838	27	811	838	4	154
1839	16	498	514	3	148
1840	11	380	391	2	153
1841	18	352	370	2	151
1842	9	338	347	1	164
1843	8	568	576	3	256
1844	12	711	723	4	384
1845	30	1083	1113	9	478
1846	58[a]**	1121	1179	11	480
1847	N/A	956	956	6	468
1848	131	1334	1465	6	454
1849	140	1719	1859	22	410
1850	64	419	483	2	397
1851	103	420	523	5	448
1852	110	583	693	5	463
1853	115[b]	385	550	7	496
1854	N/A[c]	N/A	N/A	21	512
1855	N/A	459	459	11	557
1856	N/A	657	657	21	668
1857	N/A[d]	609	609	17	683
1858	N/A	N/A	N/A	20	778
1859	N/A	N/A	N/A	24	801
1860	N/A	600	600	20	784
1861	N/A[e]	475	475	14	764
1862	N/A	N/A	N/A	27	765
1863	N/A	N/A	N/A	34	823
1864	N/A	N/A	N/A	42	729
1865	N/A	1074	1074	10	774
1866	N/A	1085	1085	19	815

SOURCE: Annual report of the Provincial Penitentiary, 1836-1866; Richard B. Splane, Social Welfare in Ontario 1791-1893. (Toronto: University of Toronto Press, 1965), 137; Museum of the Staff Induction Centre, Correctional Service of Canada, Kingston, Ontario, "Register of Deaths in Hospital Commencing 1836", in Register of Hospital Cases Commencing 1846.

*Record-keeping started January 1, 1836.

**N/A designates that this information was not available.

a. Omitted from the annual report of the penitentiary surgeon.
b. Penitentiary report not published for this year.
c. Hospital and outpatient statistics combined starting this year.
d. Statistical tables ommitted in 1858 and 1859 annual penitentiary reports.
e. Report of Surgeon not published in the 1862-64 annual penitentiary reports.

Accidental deaths were a part of the mortality at the penitentiary. Six convicts were killed by falls from the prison galleries or while involved in construction work.[21] Some convicts, though, did survive these accidents.[22] One convict was killed when he came into contact with the belt of the steam engine in the Blacksmith's Shop. The subsequent Coroner's Inquest ruled the death was due to the convict's own carelessness.[23] More lucky convicts in the prison shops only suffered badly cut fingers or broken limbs. One convict, though, had his jaw broken and another convict probably lost his arm because of an accident with a circular saw.[24] Curiously, only one prisoner was murdered by another over these years. That case in 1850 saw skull wounds irreparably worsen until the victim expired a few weeks after the incident. But since the other convict had clearly not intended to commit murder the death was considered by a court to be accidental.[25] Suicide was not a major problem either. Only eight convicts ended their own lives during this period.[26]

Many health problems of a nonfatal nature occured at the penitentiary, some requiring hospitalization and others not. Falling into the former category were some contagious diseases, serious fractures, and abdominal and pulmonary ailments. On occasion insane convicts were also housed there. Infectious diseases usually treated without hospitalization included anthrax, erysipelas, gonnorrhea, herpes, influenza, mumps, scarlet fever, and syphilis. However, apart from erysipelas, gonnorrhea, the syphilis, there were either few cases of the other diseases or they appeared in significant numbers only rarely. Most of the cases treated without hospitalization involved in minor ailments. Common health problems were abceses, boils, catarrh (colds), constipation, contusions, colic, cough, diarrhea, earache, eye inflammations and injuries, fevers, minor fractures, frostbite, headaches, hemorrhoids, hernias, haemoptysis, itch, lumbago, nausea, rheumatism, scalds, skin eruptions, sore legs, sore throats, sprains, toothaches (treated by extraction), tumors, vague internal or external pains, vertigo, and incised or lacerated wounds.[27]

However, for much of the pre-Confederation period the Surgeon could not hospitalize as many convicts as he would have wished. Until 1853 it was only a temporary arrangement, which was deficient in respect to adequate space and to the maintenance of good discipline there. Its use therefore had to be restricted to very serious cases of illness.

The construction of a hospital had been planned by the promoters of the penitentiary well before it opened in 1835. After touring penitentiaries in the United States in 1832, they had chosen to model their institution upon the one at Auburn, New York famed for its system of silent discipline. Consequently they sought advice on prison hospital design as well as on other penal matters from William Powers, then Deputy Keeper there.[28] His reply to a question about the role of the prison hospital was indeed a very unequivocal but revealing one. Convicts were not to be trusted, even when evidently sick.

> You ask "Whether any evil has resulted from the association of the sick convicts in one room?" This is a very important inquiry. The answer is, that any association or intercourse among the convicts has a pernicious tendency in proportion to the extend of the intercourse. The bad are always made worse by the bad. They not only contrive plans of mischief, but countenance and encourage each other in resisting any favourable impression that otherwise might be made on the mind of their own reflections on their past lives and present conditions, and by the sermons and pious instructions and prayers of the Chaplain, and good advice of the keepers. The evils in this point of view resulting from association, are beyond doubt very great. By being allowed intercourse, their reformation, otherwise hopeful, is rendered impossible... Hither, they are coming daily of some complaint or other from every shop in the Prison, and here they get information of each other from every part. They no doubt frequently feign themselves unwell, only for the purpose of going to the Hospital to ascertain what news, and enjoy an opportunity for sociability. I have heard it stated by our Physician, that instances had occured in which convicts by neglecting to eat, or by some other means, had designedly induced ill health for the purpose of gaining admittance to the Hospital, and by repeated trials and perseverance in this artifice, had brought on diseases which terminated in death.[29]

While Powers did admit social intercourse was a problem in the hospital during the day, he stressed that at night discipline was maintained as it could be observed by the Keeper of the Kitchen without the knowledge of the convicts there. Conversation was also discouraged by the division of the hospital into wards, similar to cells, with an avenue between the wards which the keeper on night duty could patrol easily. The convicts could thus be individually segregated, prevented from communicating with anyone but the nurse or hospital keeper attending them.[30] In spite of this judicious advice from Powers on the proper design for a prison hospital, the temporary facility at the Kingston Penitentiary proved to be very much a makeshift affair. Along with the prison kitchen and dining hall, this room or ward was located in the North Wing of the prison, in a building originally designed for cell blocks. Another building had been reserved for use as a hospital, but instead ended up being the Female Prison. The switch had been necessitated by the unexpected arrival in 1835 of female convicts at the penitentiary.[31] But the move of the hospital to another location may have been for the best, as the Female Prison proved by the late 1840s to be bug-infested and poorly ventilated.[32] At first the hospital comprised an open space, but in 1837 it was partitioned off to make it more private. It was a small area, intended to hold up to twelve patients at a time.[33] Some cooking was done there on a stove, with tableware, utensils, cups, and coffee and tea pots provided. Besides these items the hospital possessed medicines, surgical instruments, the hospital registry books, and various sundry articles. The last metioned included a thermometer, lancets, syringes, a tin cannister, spatulas, a catheter, a truss for the treatment of hernias, a pestle and mortar for mixing prescriptions, and a bedpan.[34]

Despite somewhat sketchy evidence, it is clear that Powers' prediction about the difficulty of maintaining discipline over convicts in the hospital was not without some substance. One of the questions asked convicts upon their

release regarded whether other convicts had talked to them about possible escape plans. In one case a convict had heard that another planned to saw through the iron bars of the hospital.[35] No evidence was found of this plan having been attempted. To have tried this scheme the convict would have had to feign serious illness to have gained admission to the hospital. Another convict reflected Powers' fears exactly as he reported a more concerted plan, made possible by the lack of separation in the hospital. While there a convict had asked other patients "if there were any men in the Prison that could be depended on, if he could get eleven others to join him, they would make their way out of the prison inspite of all the guards and keepers."[36] In addition, insane convicts kept in the hospital must have posed a serious problem, though not as ultimately dangerous to the institution. They could be quite noisy and disruptive of the other convicts' sleep, besides being violent towards them.[37] Clearly, then, as Dr. Sampson commented in this annual report for 1846, previous experience had proven that even to fill the hospital to capacity "would be productive of danger to the discipline and safety of the establishment."[38]

Understandably, Dr. Sampson often called for the replacement of the temporary hospital. Plans for a new facility were on the drawing board as early as May 1837, prepared by William Powers. But Dr. Sampson objected to this scheme, finding it too small and wanting in sufficient ventilation and lighting.[39] He believed that it should be built

> ...with a due regard to the attention and comfort required for the sick, be of such size as would admit the Cells or Berths to be 8 feet by 7 and that it should be of such extent that in case of emergency it might contain at least one hundred convicts.[40]

While these plans were duly modified by William Coverdale, the Master Builder of the penitentiary, nothing appears to have come out of them.[41] It may well have been that they were simply no funds available for its construction, for

by the end of 1836 the penitentiary was already burdened by heavy debts and the Government was slow to grant the institution its annual appropriation of funds.[42]

After this episode Sampson seems to have bolstered his concern for a new hospital by also raising it publicly. He first voiced this opinion in his annual report for 1840, stating "that the present partitioned space allotted for a temporary Hospital has been proved by experience to be insufficient for affording the proper maintenance of discipline therein."[43] Sampson again called for a permanent hospital when he appeared before the Inspectors in January of 1842, stating to them that it was inadequate. The Master Builder was subsequently ordered to prepare a plan of a temporary hospital for the consideration of the Board. Yet when this plan was presented at the next meeting of the Inspectors it was simply ordered to be filed for future reference.[44] In July of 1844 plans were again ordered by the Board of Inspectors, to be made up by the Master Builder in consultation with the Physician. But it then took sixteen months to complete these plans for submission to the Board, at which time this body directed that a model be made of the projected building.[45] Such delays must have been exasperating to Dr. Sampson. Understandably, he pressed strongly in his annual reports for 1844 and 1846 for the "construction of a commodious and sufficient Hospital for the benefit of the Institution."[46] However, despite the assurance of the Board of Inspectors in their annual report for 1846, this facility was not built in 1847 for occupation the next year. Nonetheless construction was started on it.[47] No doubt these delays may in part be accounted for by the great growth in the convict population, tripling from 151 in 1841 to 468 in 1847.[48] Another cause may have been the financial mismanagement of the prison by Warden Smith, as the Commission of Inquiry in 1848-49 revealed so convincingly.[49] Thus with funds scarce during the late 1840s labour diverted in building the prison meant precious lost revenue from the various prison shops and the quarry.

It remained for the hospital to be completed after the regime of Warden Smith had been ousted in 1848. Ready for use by March of 1850, it comprised the East Wing of the main area of the prison.[50] Dr. Sampson was quite gratified because, as he stated in his annual report for 1849,

> Hitherto we have had to contend with the inconvenience of having one Room or Ward to use; and to avoid congregation to much extent, none were taken into it save those whose cases were of a severe character...In the new building we shall have room, without compromising the safety and discipline of the prison for every case, as each patient will be provided with a separate cell.[51]

Yet the satisfaction felt by Sampson proved to be short-lived. In September 1850 the Inspectors decided to appropriate the hospital for a prison for the female convicts. The temporary transfer was to last until November of 1853 when a new female prison was ready. The shuffle had been made on account of the poor condition of the Female Prison and the "great difficulty of maintaining good discipline in it." Justification of this choice also came from the fact the new hospital was not yet occupied, as well as the view that the temporary hospital was still sufficient for the small number of patients there. Until the new female prison was completed the situation was viewed by the Inspectors as inconvenient but acceptable due to the "healthful state of the Institution." However, they did feel disastrous results might occur if an epidemic broke out with the larger facility unavailable.[52] Fortunately their fears were not realized as cholera, last seen in 1849 when it took the lives of seven convicts, did not fatally visit the prison again until the summer of 1854. One nonfatal case, though, did appear in 1851.[53]

Once opened the new hospital was a source of pride for the Board of Inspectors, who referred to it as a "splendid and spacious building." Two stories high, it had a strong custodial emphasis. The ranges of cells, twenty-four on one floor and twelve on the other, were designed to prevent all

contact between prisoners. The silent regimen of the prison was enforced not only by the Hospital Keeper and a Guard but by the design of the cells. They were "separated from the windows by a broad corridor, and the ranges from each other by an equally wide passage, the doors of the Cells face the windows hence the prisoners cannot see each other."[54] Moreover, it is likely that spy-holes into each cell were located in the middle corridor as they were a feature of the ranges in the male prison.[55] The roomier upper story, with cells twice the size of those in the lower story, was envisioned as a good place for convicts to carry out some light work, such as picking oakum and weaving mats.[56] Indeed, for many decades afterwards it would serve as the model for other Canadian penitentiary hospitals.

Yet the proper security of the new penitentiary hospital depended on the number of sick convicts not exceeding the available space there. When typhoid fever besieged the institution in the 1860s its hospital facilities were overwhelmed. In 1865, for example, the daily average of hospital patients was forty-two, with the lowest and highest one day totals being twenty-eight and sixty-six respectively. With only thirty-one of the thirty-six cells available, the remainder being used to house guards and orderlies, on just two days of that year was the hospital able to accomodate all of the patients referred there by the Surgeon. In 1863 this overcrowding had forced the Surgeon to put some beds in the corridors for the use of sick convicts and some of the orderlies. It was soon shown to be a dangerous solution as a brutal attack was made on one of the guards, whom the convicts involved tried to strangle in order to obtain his keys and escape from the prison. Consequently the Surgeon gave up this practice and once again only the sickest convicts were confined in the prison hospital. In his annual report for 1865 Dr. Dickson urged that additional hospital space be provided by dividing in half the larger cells on the second floor of the building.[57]

Besides improving the quality of health care at the prison by enabling more convicts with serious illnesses to be hospitalized, the new facility with its increased custodial air also served to reinforce the pervasive regimen of silent confinement. Nonetheless it needs to be asked why this much-heralded improvement in medical care took so long. The overcrowding of the prison and its financial troubles almost certainly were factors delaying its construction, but perhaps there is a more important consideratino to be grasped. For the Board of Inspectors, it may have very well been much easier to tolerate this situation than to change it. By committing only severe cases of illness to the hospital, and by pardoning some of the moribund convicts, the number in the hospital could gnerally not exceed its space for patients.

The best solution to the problem of invalid convicts during this era seems to have been achieved by the English Convict Service. In 1860 it opened the Woking Invalid Prison, specifically designed for the treatment of invalid prisoners. The main building of the institution had a hospital, and its wings contained cell blocks. The prison housed convicts who suffered from long-standing and incurable diseases, old age, and various bodily defects.[58]

That such a solution might have been implemented in the case of the Kingston Penitentiary is doubtful. It would appear that not enough invalid convicts were in the prison to justify setting up a separate institution. But, moreover, it is unrealistic to view the existing hospital facilities at the prison as grossly inadequate and long-neglected. The Upper Canadian society beyond the penitentiary could scarcely provide hospital care for its poorer citizens. The Toronto General Hospital did not open until 1829, while in Kingston both the General Hospital and the Hotel Dieu did not commence operations until 1845. Similarly, the permanent Provincial Lunatic Asylum at Toronto did not open until 1850.[59] Large scale social welfare institutions were still in their infancy, and, it should be remembered, the penitentiary was the first of

these in the province. Not insignificant, either, is the fact Dr. Sampson was the chief promoter of the Kingston General Hospital. He encountered a similarly long delay in bringing that institution to fruition. Although its building was completed in 1835, it did not open for another decade because there was no money for equipment, maintenance, or staff.[60] Clearly in both cases the eagerness of Dr. Sampson for adequate hospital facilities was in advance of what a colonial society could support. With the above considerations in mind, then, it can be said that the health care of infirm convicts was limited in scope, but not to the degree that it was neglectful of them. The procrastination of penitentiary authorities towards providing proper hospital accommodation clearly shows that this was an important, but not urgent, institutional priority. Similar delays in securing permanent hospital facilities would be experienced in the penitentiaries established across Canada in the two decades after Confederation. Some of these shortcomings would not be remedied until the 1920s. Again health care proved to be more or less subordinate to the discipline of the institution.

Chapter Four

Cholera, Typhoid, And Other Major Epidemics At The Penitentiary

The possibility of epidemics ravaging the penitentiary was always something feared by its promoters, its staff, and by its inmates. While typhus or gaol fever was not a problem there because of the cleanliness of the institution, cholera, erysipelas, smallpox, and typhoid fever did visit it. And of these four contagions, only smallpox did not prove fatal to the prisoners in the era before Confederation.

The promoters of the Kingston Penitentiary were well aware of the danger of epidemics to a closely confined prison population. In the original Act governing the maintenance and discipline of the institution, passed in 1834, provision was made to remove the convicts to a place outside the prison if a "pestilential disease" broke out.[1] In their minds must have been the cholera epidemic at the Sing Sing Penitentiary in New York State in 1832. Over a two month period there were 376 cases, 103 of which proved to be fatal, killing off one-tenth of the prison population. William Powers, who gave advice on other penal matters to the promoters of the Kingston Penitentiary, attributed this phenomenal rate of mortality to a lack of ventilation in the cells. Reflecting prevailing theories of miasmic causation, he considered that this epidemic had been caused by the inhalation of the "impure offensive air" produced by the "breath of the convict, animal effluvia, and the night-tub remains confined" in the convicts' cells.[2] Similarly, at the Arch Street Jail in Philadelphia there were at least forty-nine deaths by cholera that year. Some prisons luckily did escape this scourge but the excessive mortality elsewhere could hardly have been ignored.[3] If these premonitory signs were not enough, then the fact that construction of the penitentiary was slowed down in 1832 as workmen fled the town to escape the dread disease must have underlined to the penitentiary promoters the importance of isolating the prison from contagions.[4]

Smallpox was the first contagion to threaten the prison once it had opened. Its prevalence in Kingston endangered the institution several times before 1867, in 1837, 1847, and 1856. In 1837 sixty-two of the 123 convicts required innoculation and no cases appeared there, although there were two cases of inflammation from the vaccine.[5] Ten years later one nonfatal case did appear at the prison. Consequently the Board of Inspectors directed innoculation should take place and that the Surgeon should inspect all incoming prisoners for innoculation marks to ensure they had been vaccinated. If this had not been done previously, then it was to be carried out as soon as possible. Then only 69 of the 514 convicts required vaccination.[6] The penitentiary was again menaced in 1856 when the child of a guard who lived in one of the lodges there was infected. However, no cases appeared among the convicts.[7]

It was erysipelas which caused the first fatal epidemic at the prison. Late in December 1848 the first of eighteen cases of "phlegmonous erysipelas" broke out, with the last case appearing in mid-May of 1849. The disease claimed five victims.[8] Traditionally known as "St. Anthony's fire" or "the rose," erysipelas is an acute streptococcal infection of the skin, most usually affecting the face.[9] Fourteen cases of it had appeared at the penitentiary before 1849, some requiring hospitalization, but none had been fatal.[10] However, now its virulence was felt. Dr. Yeates, temporarily substituting for Dr. Sampson, graphically chronicled one of the fatal cases.

> January 25th- This is a lad about 19. He walked into the Surgery in a state of almost complete coma: & roused with difficulty...
> 26- Complains of sore throat. The comatose symptoms are somewhat relieved by the bleeding & purging, & now he replies to questions better...
> 27- The pulse is quicker than it was, & harder...I am now convinced that his disease is erysipelas, & that his infection if I might so call it attacked the throat first & then extended to the nose. The throat is now less inflamed. Delirium and incoherence have succeeded to the coma...
> 28- Symptoms are unmitigated, but are much worse...His face was yesterday morning covered with the eruptions & today

> his forehead is affected with it-the swelling & [?] having nearly disappeared from his face...In spite of active remedies, symptoms of meningeal inflammation have prevailed. 30- He died this morning at three o'clock.[11]

Dr. Sampson was at a loss to account for the presence of the disease. He noted in his annual report for that year that "It seems to have selected no particular locality, but to have taken place indiscriminately throughout the building; and, as respects my personal knowledge, it did not prevail amongst the neighbouring population."[12] It was not then known that this infection is most generally spread by aerial contact, with it likely transmitted by those persons recently infected who have nasal cultures of the bacteria. The prison was an ideal place for it to spread, with the inmates confined at close quarters to each other in the prison's ranges.[13]

Shortly after the erysipelas epidemic came to an end in 1849 the prison was faced with the far worse menace of cholera. The disease broke out with a vengeance on May 27th. Its first victim died a horribly agonizing death, exhibiting the unmistakeable symptoms of the disease. In his notes on the case Dr. Yeates described the rapid course of the patient towards death. Two days before he had come on the Sick List for diarrhea.

> This morning was attacked with spasms of the bowels and extremities with vomiting and purging of rice water discharge. At 12 M. he had become quite collapsed--the hands and feet being purple, contracted and the skin corrugated like a washer woman's...He died last evening at 4 1/2 p.m.[14]

Between May 27th and June 7th eight cases appeared, the first four of which died. The disease did not appear again until July 16th, but then with less vengeance. Between that date and August 14th there were seven cases and one fatality. The third and last assault of the disease came on September 6th and 7th, with both cases being fatal. As Dr. Sampson noted in his annual report,

the fatality at the prison "corresponds with the general observation, that this disease makes its first onset with the greatest violence."[15]

Although there was a general fearful expectation that cholera would again strike the Canadas in 1849, since it had broken out in England that year, it is probable that the penitentiary authorities were not expecting the pandemic to descend upon the institution at that point in the year. It was in Kingston that the first confirmed cases were recorded, with the first deaths coming on May 26th. Some doctors there thought that they had been treating cases of cholera as early as April 30th, but the disease did not recur until late May.[16] Dr. Yeates had been quick to recommend preventive measures be taken by the Warden. Considering the death on May 27th to be only an isolated case, he believed on May 29th that an epidemic could be prevented by

> ...the due cleansing & ventilation of the wings, as far as practicable with present arrangements, also that every convict be duly <u>scrubbed</u> in soap and water, at least once a week-that he have two clean shirts & two clean pairs of socks weekly[.] Leaving other suggestions for further consideration.[17]

The Warden put these suggestions into effect. He also acted on another suggestion of the Surgeon, substantially changing the prison dietary. White bread replaced brown, coffee and white bread took the place of mush, and rice was substituted for peas in the soup.[18] These were typical prophylactic measures for the period. They mirrored the common place view that disease was spread miasmically, by the poisonous effluvium that was supposed to rise from putrid matter, swamps, and decaying vegetable matter. It was therefore essential to cleanse the prison and thoroughly and ventilate it. And the change of diet presumably would reduce the possibility of convicts acquiring diarrhea, which it was thought could develop into cholera if it was not attended to. Amazingly enough, the Penitentiary Rules and Regulations of 1933, like those previously set down in 1870, 1888, and 1899, still specified that the penitentiary physician might change the convict dietary in case of an epidemic in the institution.[19]

As a physician Sampson of course feared the spread of disease through the institution. However, the greater fear of being a cholera victim must have pervaded the prison. The hospital certainly became an undesirable place to be during the epidemic. One severely dysenteric patient there was discharged, at his own request, to his range because his health had improved and his fright of being confined with the cholera patients.[20] If any convicts had not seen or heard of the ravages of cholera in the Canadas or elsewhere between 1832-34, then the swiftness of the disease and the agonized death cries of its victims, ringing through the narrow confines of the penitentiary, must have struck terror in even the most hardened convicts.

With the epidemic over at the penitentiary by mid-September of 1849, Dr. Sampson was able to draw some conclusions about the visitation in his annual report, dated October 1, 1849. He attributed the origin of the disease to miasmic influence. He reached this conclusion because cholera had appeared mysteriously at the penitentiary, coincident with its outbreak in Kingston. It could not be linked to immigration to the Canadas, as in previous pandemics in 1832 and 1834. "Animal contagion" or human intercourse was thus ruled out. Instead, as Dr. Sampson hypothesized, "It is therefore reasonable to assign as a cause of its late visitation, here, a certain epidemic constitution of the atmosphere acting in existing predisposition." He found it worth comment that the first four cases (all fatal) occurred in the less-ventilated South Wing of the prison, after which it equally attacked the other wing of the prison.[21] But as Geoffrey Bilson points out in his study of cholera in nineteenth-Century Canada, the emergence of the disease in Kingston, sometime prior to its appearance elsewhere in the Canadas, suggests that the contagion entered Kingston from the United States. It was to kill at least 130 Kingstonians.[22]

Dr. Sampson also spoke of the difficulties in diagnosing the disease.[23] At the same time cholera was attacking the prison dysentery and diarrhea were

prevalent, with nearly 200 cases of the latter. Since diarrhea was an early symptom of cholera, any cases of "disturbed Bowels" among the convicts were closely watched for by the penitentiary officers. They were to lose no time in reporting these convicts to the Hospital Keeper. Dr. Sampson could not say how many cases of dysentery and diarrhea might have turned into cholera had they not been found out and treated properly. Nor could the Surgeon comment on the etiology and pathology of the disease, considering it out of place in his report even if he could have added any new thoughts on an already much written about subject. Instead it was to the treatment of cholera that the Surgeon devoted most of his attention.[24] Both he and Dr. Yeates had tried a number of remedies against the disease, but with mixed success. The therapeutics used by both physicians here were based upon the traditional system of humoral pathology which had evolved considerably since the Middle Ages. This system of belief about the body that characterised therapeutics at the beginnings of the nineteenth century held the cause of all disease to an imbalance of impurity in the body fluids. Therapeutics comprised the removal of the fluids in question by bleeding, purging, or sweating.[25]

Physicians therefore saw the body as a system of dynamic interactions with its environment. When healthy the body was in equilibrium, but when disease struck this balance had to be restored, either by lowering or raising the constitution of the patient. 'Heroic' means of treatment were used by medical practitioners in an ardent attempt to intervene directly in the course of their patients' diseases. The virtue of a treatment, such as bloodletting or the use of voluminous doses of often potentially toxic emetics, purgatives, and other like drugs, was judged primarily by the visible physiological effect it produced. By 'eliminating' the symptoms of the disease being treated, the doctor had thus employed his best curative efforts in restoring the body's 'disrupted' equilibrium.[26] When translated from this theoretical perspective, however,

treatment often became brutal. One historian, Norman Howard-Jones, has well described the nineteenth-century treatment of cholera as "largely a form of benevolent homicide."[27] As Howard-Jones points out,

> To counter persistent vomiting, the physician came to the aid of Nature by administering emetics, and he exacerbated the intractable diarrhea that was rapidly depleting the sufferer of his vital fluids by drastic purgatives at one end and clysters at the other. The physician also constituted himself the unwitting ally of the Vibrio cholerae by practicing forced ex-sanguination of patients who were dying from want of circulating fluid. He ransacked the materia medica for new supporting treatments, and committed physical assaults upon patients ranging from 'the boiling water blister' to electric shocks.[28]

The accuracy of these remarks is borne out by an examination of the case records of patients treated at the penitentiary during the 1849 epidemic. To remedy the collapse in cholera Dr. Yeates resorted to bloodletting in some cases. This had the purpose of removing 'tarry' blood (caused by the loss of fluids) in order that the circulation of the heart would not be taxed. But in truth the bleedings, while not so harmful in patients only mildly dehydrated, served to exacerbate the condition of patients in grave need of rehydration therapy to restore the volume of the blood. In other cases Dr. Yeates used emetics in combination with rubbing the extremities to counter the heat loss of the body occasioned by the disease.[29] Dr. Sampson, in comparison, usually resorted to the use of calomel and opium.[30] The latter had anti-diarrheal properties, while the former, also known as mercurous chloride, could secure a violent physiological effect by making the patient salivate and frequently caused profuse diarrhea. Calomel was seen as the ideal bilious purgative by many practitioners who saw disease as 'venous congestion,' to be removed by a combination of bloodletting and calomel. Nonetheless the purgative came to be recognized as medically harmful by the 1860s, especially in respect to causing mercurial gangrene.[31] In using calomel Dr. Sampson noted that he was following the recommendation of Dr. Ayres, an Englishman who claimed outstanding results in

treating cholera victims with the administration to patients of very small doses of the drug at very frequent intervals. The prison doctor also gave his patients a draft of ammonium carbonate, camphor, and opium to stimulate their lowered constitutions. And to treat the depressed system by raising the fallen temperature and pulse of the patient, he used woollen bags filled with "very hot brew" which were to be constantly applied to the abdomen, sides, and back.[32]

Dr. Sampson was frustrated by the random efficacy of these therapies for he had found, in both his penitentiary practice and general practice, "that the plan which at one point of time would be followed by successful and cheering results, at another time and under apparently similar circumstances, would prove a disheartening failure." Despite the general inability of the medical profession to treat cases of cholera, Dr. Sampson defended the expertise of himself and his colleagues at a time when they were under frequent attack. Not only was the reputation and livelihood of regular doctors normally being challenged by irregular practitioners, but the cholera epidemics had shown the lay population scant proof that the former were better qualified than the latter to treat them.[33] A prominent member of the medical community, Dr. Sampson argued his profession could at least protect the community from the invasion of the disease, accomplishing this by judicious prophylactic measures and by early attention to the warning symptoms of cholera.[34] And at the penitentiary he carried these measures into effect, during his resumed tenure, by

> ...suggesting such dietary changes as seemed advisable: by recommending a strict regard to general cleanliness and frequent ablution, and by assuring myself that nothing was omitted in order to promote a free circulation of air throughout the building.[35]

The Surgeon concluded that the epidemic had been met with prompt attention and exertion by the penitentiary. Certainly both he and the Hospital Keeper had

been taxed heavily by the visitation.[36] Also affected was the contract labour carried out at the prison. The starting of one contract for fifty convicts was delayed for a month, resulting in a financial loss of the institution.[37] Yet the penitentiary had been fortunate for the death toll might have been much higher. Dr. Sampson recognized this fact when he said that

> ...although our exertions may not have been attended with entire success, yet when it is considered, that out of about Four Hundred and fifty persons congregated under one roof, only seventeen were attacked with decided Cholera, we cannot but feel that it has dealt more leniently with us, than it has done in most instances, when once located within the limits of a dense population.[38]

The penitentiary had indeed been relatively lucky. Dr. Sampson may have had in mind the extraordinary fatality due to cholera at the Ohio State Penitentiary, in Columbus.[39] There the dreaded scourge killed 115 of its 425 convicts that year, as opposed to six deaths from other causes. Even the prison physician and another physician assisting him were felled by the disease. A year before the former had drawn the attention of the State Legislature to the impending visitation of cholera, calling for the removal of all rubbish from the prison and proper ventilation and dietary in the hope of passing the forthcoming epidemic, then sweeping through Europe, with "comparative immunity." These measures were duly carried out, but from the first case on June 30th to the last case on September 17th the pall of cholera hung over the prison. Once the epidemic was over the new prison physician, like Dr. Sampson, attributed its presence as perhaps due to a miasmic influence, with the atmosphere in the penitentiary having deteriorated because of the dense population there.[40] In comparison, the nearby State Asylum was not visited by the disease and at other penal institutions in Charleston, Massachusetts, and Boston and New York City there were many cases but only few deaths at each place.[41]

It is possible the great difference in the mortality of cholera at these two institutions was due to a heavily contaminated water supply at the Columbus

Penitentiary. Either its water supply could have been tainted by the excreta of cholera victims in the nearby city of by the sewer system of the prison itself. A third explanation is possible. During the 1840s this penitentiary was overcrowded, with its administration lax and the convicts well-organized. There the silent system had effectively broken down and the convicts were able to communicate with each other, a situation which may have helped to spread disease throughout the institution.[42] But at the Kingston Penitentiary both the discipline of the institution and its water supply appear to have been in good condition. Its discipline was effective enough to ferret out those cholera victims who preferred to avoid the rigors of medical treatment for it. One poor victim of the 1854 epidemic was very reluctant to go on the Sick List and had to be dragged into the hospital.[43] And the prison drew its water supply from Lake Ontario, at a point not far from where its sewer--into which each convict daily emptied his 'night-tub' of excrement--fed into that body of water. In the 1860s, however, typhoid was rampant in the institution and the quality of its water supply came under serious scrutiny.[44]

This combination of an apparently good water supply and tight discipline may serve to explain why the penitentiary was able to weather well both the 1849 and 1854 epidemics. In the latter twelve convicts died, out of twenty-eight cases of the disease.[45] It was the third visitation of cholera to the penitentiary, the second having come in 1851 when one nonfatal case had appeared.[46] This minor outbreak was mostly confined to Quebec and Montreal where about 200 had died. In 1854, however, the last major epidemic of the disease assailed the Canadas, claiming about thirty-six hundred lives. The pandemic was brought to Quebec City by ship passengers from England. From the first confirmed cases there on June 20th it quickly spread elsewhere, with Kingston and Toronto reporting cases on June 25th.[47] Two days later the forewarned Penitentiary Inspectors inspected the whole institution for its cleanliness. Finding all

correct they nonetheless ordered that

> ...in any case of Cholera or other epidemic visiting the Penitentiary the Warden will take every precaution in keeping everything as clean as possible and using ashes, lime or lye in and about the Water Closets daily and removing such lime or ashes as have been in use every day and that lye or lime water shall be put in the South Wing occasionally and that the orifices shall be kept closed.[48]

The Inspectors did not have long to wait for the pandemic to reach the prison. On July 21st the first case appeared, followed by twenty-one cases over the next ten days, ten of which proved to be fatal. Again cholera followed the pattern of first breaking out with a vengeance. It flared up for a second and final time on August 13th, with two fatalities among the seven cases. On August 24th the last of these cases appeared.[49] And once more it disrupted the daily routine of the prison. An examination of the Warden's Daily Journal, extant for this period, reveals that these disruptions caused some tempers to flare. This unrest showed that, as in the community outside its walls, the outbreak of cholera served to mirror normal day-to-day tensions in the prison society. On the first day of the epidemic a profit-hungry labour contractor wanted to halt work because one of his best workers had gone to the hospital, but the Warden urged him to continue.[50] Similarly, on his nightly inspection that day the Warden found the prison all quiet, free of the occasional clandestine noises made by convicts. He accounted for this state by saying that "the death this day by cholera has caused a feeling of dread in the minds of all."[51] And the brusque Hospital Keeper Whymann, overworked during the epidemic, complained his work was being interfered with by one of the keepers. If he did not receive more help he threatened to leave his post.[52]

In contrast to the 1849 epidemic was the reaction of the Inspectors, who now were intrigued that cholera was not contagious or infectious in regard to the penitentiary, for it did not spread through the area of the prison where it first occurred or to other hospital patients and to those who attended the cholera

victims. Like many others of their era, the Inspectors had found cholera a truly mysterious disease.[53] In the second epidemic medical treatment of the disease did change somewhat, with a set remedy replacing the range of approaches tried in the 1849 epidemic. Now calomel and opium were combined with a draft of camphor and ammonium carbonate in order to stimulate the lowered constitution of the body. As well the body was rubbed externally with lotions and mustard plasters were applied to it.[54]

The final visitation of cholera to the penitentiary came in 1865, with one fatality among the four convicts attacked by the dreaded disease. Fear of the disease was especially present a year later because of recent outbreaks in Europe. However, the institution was spared and a relieved Dr. Dickson prayerfully thanked God for his mercy in delivering them from this "direful calamity."[55] Yet the Surgeon then had on his hands an equally troublesome menace, as typhoid fever lingered at the penitentiary during the 1860s. It caused sixty-six deaths. As noted earlier, the disease strained the hospital facilities at the prison as hundreds of cases of it occurred each year. In 1864, for example, there were 352 new cases, with twenty-nine patients from the previous year still on the Sick List. And of all these cases, twenty-one convicts fell victim to the disease.[56]

The typhoid fever epidemic was caused by an impure water supply and the reception in 1862 of an American Civil War deserter who carried the disease.[57] Several measures were taken to control the epidemic. In 1863 and 1866 the water supply pipe of the prison was extended further out into the lake in order to meet the current and to avoid contamination from the sewage outfall of the prison.[58] Another expedient was to clean the penitentiary drains and to cart away the sewage for use as manure on the institution's farm. In addition, in 1862 charcoal filters were installed in the prison cistern in an attempt to purify the water.[59] Yet this particular action seems to have been very ineffectual. In his

annual report for 1865 Dr. Dickson drew attention to continuing impurity of the prison water supply.

> The water that is supplied for all purposes to the Prison is still very impure, and at times its pollution with human ordure is too apparent to the naked eye. A few weeks since, I ascended to the Water tank, with two of the Officers of the Prison; a living eel, over two feet long was caught in the tank; a perch about seven inches in length, was sporting there, too. Of the presence of the living fish I might not complain, but we also found the head and shoulders of a large fish, and the tail and portion of the body of another, in a putrid state. In addition to this, we found the water in the tank polluted with human filth.
> I have long been convinced that the impure water which is served to the convicts for all purposes, is the cause of a great deal of the sickness with which we have been harassed in the Prison for the past few years.[60]

While it was now clearly recognized that contaminated water would produce disease, problems of water supply and sewage disposal would continue to pose difficulties for the remainder of the nineteenth century.[61] Proper sanitation was not an easy task in an institution containing hundreds of persons.

Like cholera, the presence of typhoid fever disrupted the normally strict and ordered routine of the Kingston Penitentiary. The amount of labour done by the convicts was greatly reduced at the times when the epidemic was raging, and the prison discipline suffered as less emphasis was placed on detecting malingering convicts lest they might in fact be ill from the disease.[62] In the case of both contagions, the importance of proper medical care to the success of the prison was underlined. The prison authorities certainly did their best to cope with cholera, which to them was a truly puzzling disease. And in this case the rigid discipline of the penitentiary did unquestionably benefit the welfare of the convicts, serving to identify and isolate for treatment reluctant convicts seized by the disease. Similarly, with smallpox it could be ensured that all convicts were innoculated against it. As well, the water supply of the penitentiary may have provided a good measure of protection against cholera, although the institution's authorities did not then view it as a potential source

of contagion. However, the penitentiary authorities were not so lucky in their fight against typhoid fever. Nonetheless during the pre-Confederation era epidemics did not prevent the penitentiary from generally fulfilling its purpose of providing a punitive long-term confinement for convicts.

Chapter Five

Recognizing A Problem: The Treatment Of Insane Convicts Until 1851.

Of all the sick convicts in the Kingston Penitentiary, those who were insane presented the greatest obstacles to the operation of the institution. Ranging in temperament from the harmless imbecile to the violent and demented psychotic, these prisoners, though normally few in number at any time, were an awkward and controversial group for the prison authorities to manage. Generally unfit for work, they were an economic drain on an institution not originally intended to house them. In addition, violent lunatics posed a threat to the safety of the prison staff and to other convicts. Suicide attempts by these convicts also had to be guarded against. While such convicts could be removed from 1845 onwards to the Provincial Lunatic Asylum at Toronto, this procedure was in fact not always a simple or certain solution. And the practice complicated matters by tempting a few sane but desperate prisoners to feign insanity in the hope of relief from the monotonous and strict regimen of the penitentiary, regardless of the harsh punishments awaiting them it their duplicity was detected.

During the pre-Confederation era the treatment of these convicts changed considerably, concurrent with the gradual recognition by prison and government officials in the nineteenth-century of the existence of a criminal lunatic class of convicts. Proof of this recognition came in 1851 when the penitentiary authorities were, by statute, given the power to commit convicts certified by a board of physicians as insane to the Provincial Lunatic Asylum at Toronto.

Lunatics, of course, had been incarcerated in gaols and prisons before the opening of lunatic asylums in North America in the early nineteenth century. The former places were secure but often filthy and unhealthy places of confinement for those lunatics who were destitute or whose behaviour was disruptive or

socially threatening to the community. Otherwise, as T.E. Brown points out in the case of Upper Canada, families were expected to bear the major burden of caring for their insane members.[1] With the advent of asylums and penitentiaries the insane were institutionalized in the former while the latter was reserved for the deviant criminal. Prison reformers like Louis Dwight, founder and secretary of the influential Boston Prison Discipline Society, scorned those gaols and prisons where this practice still existed in the late 1820s and 1830s. In 1827 he cited one prison in Massachusetts, where a mad convict was found in a ramshackle cell with only rags and clothing and a "heap of filthy straw, like the nest of swine" for his bed.[2] In the transformation from the local gaol to the penitentiary the role of asylum was thus gladly shed by the promoters and administrators of penitentiaries. In an institution aimed at deterring deviance by punishing criminals through an arduous period of confinement, insane convicts were especially not welcome. Exempt from punishment because of their mental state and capable of little if any work at all, such convicts were only a disruptive burden upon penitentiaries.

In the first decade of the Kingston Penitentiary the incidence of insanity reported by officials there was rare. Record was found of only one case, in 1843, while another convict was earlier, in 1838, suspected of being deranged in intellect.[3] William Powers, then the Deputy Warden, was truthful in 1839 when he replied to Louis Dwight's query about this matter. Referring to the 280 convicts received up to that date, he sanguinely stated that

> There has been no case of insanity in this Prison since its commencement; and I believe that few or no cases of insanity, in a Prison well conducted, need be expected, which shall be produced by the confinement. I think a good system of discipline, wisely and efficiently enforced, yet administered in a humane and Christian spirit, will be far more likely to <u>prevent</u> insanity rather than to produce it.[4]

In speaking about the subject Powers was no doubt implying that the Auburn or congregate system of prison discipline only rarely caused insanity among convicts, in contrast to the Philadelphia or separate system which was greatly condemned by supporters of the former for its proclivity to drive convicts mad.[5] In the so-called Philadelphia system each prisoner was lodged in a cell where he remained day and night during the entire period of his confinement. There he laboured and slept in absolute isolation from the other convicts. From the 1820s to the 1850s these two rival systems provided models for the wave of penitentiary construction which took place in Europe and North America.[6]

The rarity of recorded insanity in the first decade of the Kingston Penitentiary may be related to the absence of a lunatic asylum in Upper Canada to which such convicts could be sent. When a temporary Provincial Asylum was opened at Toronto in 1845, it did offer a convenient outlet. The Penitentiary Inspectors soon took advantage of it, sending a convict there in July 1846. This procedure involved applying to the Government for a Governor-General's warrant to commit the convict to the asylum, at the same time giving him a free pardon from the prison.[7] It was definitely a long-term solution to the management of these convicts when it is considered that most of the civilian convicts at the prison served a term of three years. In contrast, the convict who went mad in 1843 was only a short-term problem for the prison authorities. He was a military prisoner serving a term of six months.[8]

Curiously, plans had been made by at least 1837 for the provision of separate cells for lunatics, removed from the main building of the prison.[9] However, there is no evidence that these cells were ever built. The lack of a proper place of confinement in the prison was only somewhat remedied in the mid-1850s by the erection of the permanent hospital, with its cells, and a temporary prison asylum. The latter facility was first located in part of the West Wing in 1855, but a year later severe overcrowding at the prison forced its

removal to the dining hall basement. Consequently until then such convicts could only be confined in their cells or in the open ward of the temporary prison hospital. In each location the noise made by some lunatics disrupted the silent regime of the prison, particularly being a nuisance at night when the sleep of other convicts would be disturbed.[10]

Notwithstanding the confidence shown publicly by Powers about the mental health of the convicts, the evidence in fact points to the existence of a very different situation during much of the 1840s. As the Commission of Inquiry revealed in its investigation in 1848-49, insane convicts had often been punished severely for violating the rules of the institution. It was supposed that they had been continuously feigning insanity.[11] The same kind of abuse was also common in American penitentiaries during this era. Once convicted as sane inmates were rigidly regarded as so during their confinement, despite their incaution to further punishment when they continued to break prison rules. In practice this very crude perception of insanity by the wardens of these institutions meant, as one American penitentiary investigator stated in 1840, that they

> ...tended to consider every manifestation of insanity as an attempt at deception, and punish it accordingly. This rule was not departed from in cases where the manifestations of insanity were so clear, that it would seem impossible to have mistaken, or overlooked them.[12]

In the one recorded instance during this decade where a convict was caught feigning insanity his case had been carefully investigated, including his behaviour in gaol before entering the prison. The convict had represented himself as epileptic and deaf and dumb. Because of his "apparent idiocy" he was first kept in his cell and then moved to the prison hospital, presumably for closer observation. By this ruse he was able to escape hard labour for more than twelve months. But from information supplied by the authorities of the District where he was convicted and from the close scrutiny of the Hospital Keeper his duplicity was found out. After being confronted with this evidence the convict

confessed to the imposition, for which he was put on a diet of bread and water, lashed, and confined to the coffin-like "Box".[13]

The found-out convict certainly did not get off easily for his deception. The forms of punishment prior to the removal of the regime of Warden Smith were particularly harsh ones. Some convicts definitely found them injurious to health, as they attested to upon their release.[14] Chiefly employed was the feared cat-o'-nine-tails which, when expertly used, could cut a man's skin with almost every lash. Convicts frequently fainted upon the whipping triangle to which they were tied during flogging. Similar to the cats, as this punishment was commonly known, was the rawhide which always made ugly, discoloured welts on the back. Other punishments included shackling convicts, strait jacketing, solitary confinement, and the "Box." Of these it was the "Box" that was most dreaded by convicts. Resembling a stone coffin, convicts stood erect in it for up to nine hours.[15] After 1848 its use was abolished and corporal punishment was used sparingly, on those convicts whose behaviour was intractable.[16]

Severe means of punishment could only exacerbate cases of mental derangement, and also perhaps for a few convicts it served to hasten them into insanity. The stark truth of this abuse was all too clear in the testimony heard by the Commission of Inquiry. In one case, a military prisoner had received 168 lashes of the cats and the rawhide combined. He had been punished for a variety of offenses, most of which concerned the assault of keepers, guards, and other convicts. According to one keeper the assaults on other convicts were usually made without apparent cause. The convict also occasionally exhibited self-destructive behaviour, beating his head against the flagstone pavement of the prison. Understandably, a good many of the witnesses before the Inquiry thought he was insane. But Warden Smith, speaking in defense of his actions in this case, told the Commissioners that he only gradually became convinced of the

convict's lunacy. In the meantime he had, with some justification, believed him to be feigning insanity. The convict's commitment warrant specified that he had, without apparent reason, violently assaulted another military prisoner, similarly struck a military guard, and feigned insanity. And the Warden was warned that the convict would feign insanity. In this context he had to suffer floggings repeatedly, until his demeanour convinced a suspicious Dr. Sampson of his insanity. The convict was then promptly removed to a military hospital.[17] The Commissioners, however, found the Warden's defence to be a poor one.

> His attention had been specially called to the fact that symptoms of madness, whether real or feigned, had been exhibited by Donovan; and while it was his duty to guard against being imposed on by the simulation of insanity, it was much more his duty to investigate closely and bear patiently with such a subject, until it was clearly ascertained that he was a responsible agent...It is very clear that if the man was deranged when he arrived, or had any tendency towards it, that the treatment he received was calculated to drive him into hopeless insanity. We think no one can read Donovan's committal, and the list of offences committed by him in the Penitentiary, without coming to the conclusion, that he was not sane.[18]

But two other cases of convicts later declared insane after severe punishments at the prison in the 1840s captured the lion's share of attention at the Commission of Inquiry. Exhaustive inquiries were made into the cases of James Brown and Charlotte Reveille, with the report of the inquiry containing the lengthy correspondence pertaining to the heated dispute over their sanity.[19] These two cases provoked a controversy which is richly illustrative of the varied contemporary views of the criminally insane. This difference of opinion ended up principally involving the Surgeon, the Warden, the Board of Inspectors, and the Government. In the process, the quarrel called into question the professional capacity of Dr. Sampson, who had certified them insane, and laid bare the harshness and inflexibility of the discipline of the penitentiary under Warden Smith.

James Brown was admitted to the penitentiary in November 1840, under a sentence of life imprisonment for rape. He had been condemned to hang but his sentence was commuted to transportation for life, committing him to the prison until he could be sent together with other convicts to a penal settlement. However, this expedient seems to have fallen into disuse and Brown remained in the prison. Throughout his confinement his behaviour was, as described to the Commissioners by one of the Penitentiary Inspectors, "an almost uninterrupted scene of violence and outrage; many times threatening to take the lives of the Officers of this establishment, and still threatening to commit murder."[20] Consequently between 1843 (when accurate punishment records began) and 1848 Brown received a total of 1182 lashes, and was numerous times put in solitary confinement, shut up in the "Box", placed in irons, and given on a diet of bread and water.[21] Brown also showed evidence of dementia, breaking into paroxysms of rage at what he believed was his unjust imprisonment.[22]

During all this time the Warden considered Brown to be a violent, bad character who was bettered by punishment. Some of the keepers and quards who testified before the Commission of Inquiry shared this view, with many stating that the conduct of the convict had remained the same since he came to the prison. Other keepers and quards, though, held the opposite view on this occasion, stating that Brown had often been punished for acts committed while insane. As well some keepers and guards were not sure if he was insane, but leaned towards thinking he was. As one witness said, Brown sometimes talked sensibly but at other times spoke in a deranged fashion.[23] It is worth noting, too, that some convicts had commented about Brown upon their liberation from the penitentiary. Three of them believed he had been harshly punished, while two others were convinced that he deserved what he got.[24] All in all, the case of Brown was controversial issue at the prison.

With such a diverse range of views about this prisoner, it is not surprising that controversy quickly developed over his certification as insane. Dr. Sampson took this action on February 16, 1848, declaring to the Board of Inspectors that Brown was of "unsound mind." The Surgeon had only taken this step after careful examination of Brown's conduct and the punishments inflicted on him. He had suspected Brown was insane since December 30th of the previous year, on which date he had halted the flogging of the convict. Dr.Sampson had then stated in the Punishment Book of the prison that the convict was only "fit as to bodily health." Consequently a punishment of bread and water was substituted in the interim before he was declared insane.[25]

Dr. Sampson later testified before the Commission of Inquiry that Brown was the callous kind of man whose bodily health sustained frequent punishment, but whose mental health would be affected by ill-treatment. His suspicion of Brown's insanity had been influenced by several circumstances. The first of these involved the two cases earlier that year where he had sanctioned the punishment of Brown, as required by the order of the Government in 1846 that all punishments ordered at the prison, lest they injure the health of the convict, also had to be approved by the Surgeon and that his presence was required at their infliction. On both occasions Brown was given thirty-six lashes for such offenses as threatening to murder keepers, for cursing profanely, for threatening to raise a mutiny in the prison, and for greatly disturbing the whole prison by making a noise in his cell. The second circumstance taken into account by Dr. Sampson was having heard that Brown had often been punished. The third circumstance influencing the Surgeon's decision was his having been an eyewitness to Brown's conduct on December 30, 1847. For that episode the convict had been awarded thirty-six lashes for outrageous conduct.[26]

Relations between the Surgeon, the Inspectors, and the Warden deteriorated when Dr. Sampson stopped the flogging of Brown. But the Inspectors, by disagreeing with his diagnosis, set the stage for acrimonious controversy when

they did not report the case to the Government until April 8, 1848. In the interim they sought information about Brown's background and other medical opinions on the case.[27] Meanwhile, a second controversial case of insanity was also dividing the penitentiary hierarchy.

The case of Charlotte Reveille followed a similar path to bitter dispute. Reveille arrived at the penitentiary in mid-1846, sentenced to a term of three years for larceny. Her confinement was continually characterized by violent and unruly conduct. She was always striving to destroy her bedding and clothing, and in late 1847 she had tried to commit suicide by hanging herself. As well she was often insubordinate to the prison staff, cursing them, and devious in her attempts to avoid punishment, by feigning illness. These acts brought down harsh chastisements on her, often confinement to the 'Box' or to a solitary cell in addition.[28] In April 1847 the Inspectors even ordered her gagged "whenever it be necessary to reduce her to silence."[29]

The continuing violent and turbulent conduct of Reveille again brought her to the attention of the Board of Inspectors on January 15, 1848, who then requested from the Surgeon a certificate as to her sanity in the event she had to be removed to a lunatic asylum. He quickly complied, reporting two days later that "she labours under a species of mental derangement which may be termed moral insanity."[30] Dr. Sampson had been acutely aware of the troublesome conduct of Reveille since she entered the penitentiary, particularly since the previous October when she was admitted to the prison hospital for her bodily ill health. Her hospitalization was mostly characterized by violent and unruly conduct.[31]

The diagnosis, however, made by Dr. Sampson of the insanity of Reveille did not satisfy the Board of Inspectors. Rather than ascribe her derangement as due to an obsessive and obvious disorder of the intellect, such as mania, Dr. Sampson had instead labelled it "moral insanity." "Moral insanity," as described by James Cowles Prichard, an English alienist credited with first describing the

concept, was a condition affecting the emotional and volitional powers of the mind. Instead of a loss of reason, the lunatic retained his intellect but suffered from disturbed emotions caused by a loss of will power.[32] Writing in 1842, Prichard stated that,

> In cases of moral insanity the moral and active principles of the mind are strangely perverted and depraved; the power of self-government is lost or greatly impaired; and the individual is found to be incapable, not of talking or reasoning upon any subject proposed to him, for this he will often do with great shrewdness and volubility, but of conducting himself with decency and propriety in the business of life. His wishes and inclinations, his attachments and dislikings have all undergone a morbid change.[33]

Unhappy with this diagnosis, the Board of Inspectors sought background information on the convict and other medical opinions.[34] And, as in the case of James Brown, the conditions were ripe for rancorous dispute over the sanity of a convict.

It is essential, before proceeding to an examination of the ensuing controversy over these two cases, to focus upon other altercations involving the Surgeon, the Warden, and the Board of Inspectors late in 1847 and through the first half of 1848. Reference to these events is important because they led to a crude intrigue directed against Dr. Sampson. His strong reaction to the attempts to secure his removal by smearing his professional reputation resulted in administrative breakdown at the prison and was a major factor in the calling of the Commission of Inquiry in 1848.[35] But, most significantly here, this cabal provided an acrimonious and complicating background to the dispute over the insanity of James Brown and Charlotte Reveille.

With the autocratic regime of Warden Smith in place at the prison until November 1848, the discipline exercised over the convicts was, by the late 1840s, sometimes very lax but other times severe. Punishments were then meted out harshly and in great numbers. Perhaps worse was the fact that many convicts were close to starvation, with their rations scant and often tainted because of the

peculation then rampant at the prison.[36] It was only inevitable that this exercise of unrestricted power would be challenged. Dr. Sampson, with semi-independent status at the institution, would prove to be an important factor in the undoing of Warden Smith's regime.

An integral part, of course, of Warden Smith's autocratic handling of the prison was the installation of officers who were wholly supportive of him. By November 1846 he had a new and sympathetic Board of Inspectors and a new Deputy Warden, eliminating two previous sources of criticism to his running of the institution. The Warden then appointed his son, Francis (Frank) W. Smith to the post of Kitchen Keeper. It was a clear example of nepotism. But such moves only paved the way towards complete administrative breakdown at the prison. Not all its staff agreed with how it was being run, as would later be very apparent in the testimony heard by the Commision of Inquiry. The result was a shallow administrative peace at the penitentiary.[37]

Dr. Sampson challenged this state of affairs in October 1847 when he laid four charges of misconduct against Frank Smith. Before the Board of Inspectors Dr. Sampson charged him with shooting arrows at convicts, leading to the loss of an eye by one; with taking improprieties wiht the female convicts; with taking convicts fishing; and, finally, with the appropriation of penitentiary stores for his own profit. Smith was found innocent of the charges, but the affair made for a bitter relationship between him and Dr. Sampson, who appealed the decision to the Government.[38] The Commission of Inquiry would later rule that this trial had been improperly conducted, and should instead have convicted Smith on the evidence tendered. It also pointed out that more incriminating evidence could easily have been obtained by the Inspectors.[39] Not surprisingly, the removal of Frank Smith from his post was the first reform at the prison undertaken by the Commissioners.[40] Moreover, as Christopher Norman points out in his valuable study of the Commission of Inquiry and the events surrounding it, the trial of Frank Smith

> ...was particularly important because it precipitated a distinct cleavage between the two loose factions within the institution; "those officers who gave evidence unfavourable to Smith and their friends ranged on one side, while such as testified for him and their friends went on the other, and a bitterness of feeling between them gradually increased."[41]

The stage was thus set for a far more rancorous episode in the continuing internal conflict over the administration of the penitentiary. In February and March of 1848 a crude plot was put into action to remove the Surgeon from his post. However, it had the effect of provoking Dr. Sampson to call for a Government inquiry into the affairs of the institution. The tumult started in late February when the Assistant Matron of the Female prison complained of the conduct of Charlotte Reveille while being examined by the Surgeon. She appeared to imply in her complaint that the Surgeon was quilty of "undue familiarity" towards the convict. The Inspectors believed that they were duty-bound to investigate this incident, since they were empowered by law to "examine and inquire into all matters connected with the government, discipline, and police of the said penitentiary." A meeting was convened on March 3rd to hear testimony into the matter, at which the Surgeon's presence was requested. However, Dr. Sampson only briefly attended the meeting. Refusing to testify into any investigation of his conduct, he protested against the proceedings of the Inspectors and thereupon immediately left the prison. The Inspectors then heard testimony from the Matron and the Assistant Matron. The latter notably testified that Dr. Sampson, who appeared to have been drinking on the night in question, had laughed along with the convict. She thought but was not certain that Dr. Sampson, on this infrequent night visit, had touched, at Reveille's urgings, the convict's "private parts." Both these women were suspicious of his conduct towards her as they believed he was, in his constant attention to her, being unduly kind to a convict who was feigning illness. But without the testimony of the Surgeon in hand, the Inspectors declined to come to any decision on the matter.[42]

No doubt aware of the cabal against him, Dr. Sampson appealed to the Government to investigate affairs at the penitentiary. At the same time the Inspectors, sharply rebuffed by the Surgeon but with evidence detrimental to him, called on the Government to look into this episode and forwarded to it the testimony taken at the hearing. The same letter was sent to Dr. Sampson, provoking him to send an angry letter to the Government. In it he stated that he had constantly attended to the convict for her serious bodily ailments, also fearing her death on the day of his contentious visit.[43] Clearly enraged, he wrote on March 9th that

> I have acted as Surgeon to the Penitentiary, for nearly fourteen years, and during all this time have endeavoured to fulfill my duty to the utmost and especially in aiding to carry out its discipline by attention to the directions conveyed to me; and yet it is not attemped to be showed that I refuse to obey the orders of the Board. The present is not a question as to enforcing the Prison discipline, but an attempt to bring my character and conduct under a judgment.[44]

On March 3rd Dr. Sampson had further deepened the conflict, perhaps injudiciously. In the Hospital Register Book he recorded, along with his case notes on Reveille, that "I may remark in this place, no credence is to be given to anything said when animosity and deceit seem to govern the actions of persons in office. I reported this convict insane, to the Board of Inspectors on _____ _____[January 18, 1848], and I feel convinced that no improvement can take place mentally, while in this Prison." By March 15th this entry had come to the attention of the Inspectors, who summoned Doctor Sampson to come before them to explain what parties he had referred to there. In response, by letter, Dr. Sampson stated that he would only discuss the matter in writing, until called before the Commission of Inquiry whose appointment (as he had been told by the Government) was impending. The Board responded by informing the Government of these events, citing the ambiguous statement in the Hospital Register and stressing that the discipline of the institution was threatened by the Surgeon's disrespect for their authority.[45]

When the Commission of Inquiry did meet in the summer and fall of 1848, it considered this episode in detail, as part of a number of charges laid against Dr. Sampson by the Board of Inspectors. The other charges concerned his disobedience of their orders, charging other officers with improper conduct, refusing to appear before them, and maliciously publishing their proceedings. Also heard by the Commissioners were a number of revengeful charges made by Frank Smith against Doctor Sampson, all of which were easily dismissed.[46]

Scrutiny of the alleged "undue familiarity" taken by Sampson in his examination of Reveille revealed that the Assistant Matron now told a different story from that which she had given in a deposition to the Inspectors. Her latter version of the incident in fact refuted all the incriminating aspects of her earlier testimony, in which, as it turned out, she had been encouraged by the Warden and his wife. Even so, the Commissioners considered that if the earlier version had been true it nonetheless did not justify a trial of Doctor Sampson on such a weighty charge. It would, according to the report of the Commission," only prove that the Surgeon was one night somewhat excited, humoured an insane patient more than was advisable, and laughed." In concluding their examination of this charge, they stated the actions in this matter by the Inspectors had been "highly improper" and deeply wrongful to Dr. Sampson. It was further noted that their judgment here was strengthened by a knowledge of the controversy previously existing between the Surgeon, the Warden, and the Board of Inspectors. Also dismissed were the other charges of the Inspectors.[47]

The resolution of this trumped-up issue points, though, to another problem related to the care of insane convicts: the need to certify them as indisputably insane. Otherwise the prison staff could become very seriously divided over the question of a convict's insanity. It was a moral judgment by each party which left no room for compromise. The matter of the mental state of Charlotte Reveille was therefore ultimately determined by the power relations of

the participants involved, rather than by reliance on a medical opinion as the final word on the subject. And the Commissioners, who ended up making that decision, were convinced of the insanity of Reveille, choosing to label her as "the freak of the mad woman."[48]

It was with this background of acrimonious controversy that the Penitentiary Inspectors finally reported to the Government on April 10, 1848 that Dr. Sampson had months earlier certified both Brown and Reveille to be insane. They might have delayed this action had the Surgeon not been pressing them on it. In their report to the Government they stated their own reasons for disputing the ruling of the Surgeon, with his request that a free pardon be granted in both cases so that the two convicts could be removed to a lunatic asylum. Instead, the Inspectors considered that they were fully justified in not proceeding on the Surgeon's advice until the two cases could be examined further. Their decision was based on a personal examination of Brown and on information from officers of the prison who were in close contact with Reveille. Also influencing their judgment were statements from the former gaolers of these convicts. In addition the Inspectors took close aim at the diagnosis of "moral insanity" in Reveille's case, citing a recent English law case where its use as an insanity defence had been rejected. With these considerations in hand, the Board of Inspectors requested the permission of the Government to allow these cases to be investigated by the Medical Superintendant of the Provincial Lunatic Asylum, at Toronto, and by the Head of the Military Staff of Upper Canada.

At the same time the Inspectors were careful to state that they were not challenging the professional capacity of the Surgeon. Though they no doubt tacitly considered Reveille to be utterly sane, judging from the vigorous fashion by which they pressed the matter of "undue familiarity" involving thesis convict, the Inspectors maintanined the choices Dr. Sampson had made in these cases were difficult ones and deserving of re-examination. They believed that special

expertise in this area, something which Dr. Sampson himself did not claim to have, was required because "nothing is so difficult as to determine the difference between an inferior grade of mental alienation and feigned insanity, and that it required very special attention to that particular branch of the profession to enable a physician to attain any great eminence in it."[49]

In the case of Reveille, the evidence of her Gaoler at Montreal showed that her confinement there was often marked by mischievious and destructive conduct. Frequent punishments of solitary confinement had only stiffened her resolve against being disciplined; instead he found the use of his kindness and moral suasion more effective in managing her. The Gaoler, however, at one point had been forced to handcuff her arms behind her back to prevent her from destroying her own clothes. While he sometimes suspected she was insane, both the gaol physician and himself found her sane after a close examination.[50] No such hesitancy, however, was expressed by one of the captors of James Brown. The sheriff who transported him from Chatham in South-Western Upper Canada saw, like others there, that he was not mad, but rather that his conduct proved him more of "an untameable ruffian than anything else."[51]

On April 25, 1848 the Provincial Secretary of Canada West wrote to the Inspectors with the reply of the Governor General regarding the disputed insanity of the two convicts. The Inspectors were commanded to retain the convicts, as insane, in the penitentiary in lieu of removing them to the Provincial Lunatic Asylum at Toronto. The Government strongly considered that the removal of Brown and Reveille to the asylum would have been the proper course if these were clearly cases of harmless lunacy or incurable imbecility, but inappropriate where the prisoner was outrageous and violent. At the same time the hope of a cure for these convicts while in the prison was in the mind of the Government. The argument was conceded that a free pardon not be granted as the release of the cured convict might endanger the social fabric of the community. At the same

time, however, the arrangements for lunatic convicts at the penitentiary were not "by any means complete" unless such cases could be treated there. Once recovered they could be returned to the normal routine of the prison; on the other hand, if such cases became hopeless, then removing them to an asylum was appropriate on the expiration of their sentence.[52]

Also squarely addressed by the Government in its reply to the Board of Inspectors was the sanctity of the medical opinions of the Surgeon of the penitentiary. At stake was the question of whether convicts reported by the Surgeon as insane, but considered sane by the prison authorities were to be punished while their mental status was under dispute. In the view of the Government they had not become "moral agents and fit subjects for punishment while so reported." It was firmly stated that the Surgeon "must be considered competent to express an opinion in all matters regarding to the health of the prisoners under his medical charge." As well, his actions in the course of his duty were "not to be considered actuated by improper motives." It was a stiff rebuke underlined by the judgment that the punishment of such convicts could not be condoned if the professional opinion of the Surgeon had in error been overruled. Further medical opinions on the two cases were also ruled inappropriate, at that moment, for the Government had wholly agreed with the Surgeon's opinion about the insanity of the two convicts. The impending release of Reveille was seen to rule out the possibility of her feigning illness to gain a pardon. In addition her conduct, heedless of continued punishment, and her diseased body made her insanity hardly extraordinary. Similarly, James Brown could scarcely have endured eight years of severe punishments for the same reason.[53]

The Provincial Secretary also stated that such a judgment on the sanity of the two convicts could only be conclusive upon the investigation of the Commission of Inquiry, which he announced as forthcoming pending the appointment

of Commissioners to it. In the meantime it was felt that the ends of criminal justice would not suffer if the two convicts were treated as insane.[54] The Board of Inspectors quickly replied a day later. In a sycophantic but self-justified tone they agreed with the decisions handed down and affirmed that the required changes had been implemented.[55]

When the Commission of Inquiry met it closely examined these two cases as part of its indictment, on many counts, against Warden Smith. Consequently he was found quilty in the cases of Brown and Reveille, as in three other cases, of "goading, by excessive punishment," the convict "into a state of insanity, or in aggravating the malady under which he laboured." About Brown the Commissioners concluded that even if an alternative treatment had been tried upon him, the severe and continuous punishments still "greatly aggravated his predisposition to insanity." Rational as Brown was considered to be at times, they deduced he had become insane from the ill-treatment and had been in this state since the date Dr. Sampson certified him so. No doubt a contributing factor to this decision was the fact the Warden had deliberately chosen not to report all of Brown's punishments to the Surgeon, information which the latter had requested when he was examining the convicts sanity.[56] The Warden had also tried a similar evasion of the truth before the Commissioners, attempting to show that some of the punishments meted out to Reveille had in fact not been given.[57]

Interestingly enough, the Commissioners did not make any substantial recommendations about the treatment of insane convicts in their final report, except to recommend that apartments to house and treat insane convicts should be built.[58] They did, however, tour a number of American penitentiaries as part of their investigation into the penal reform which they clearly believed was necessary at the Kingston Penitentiary. After touring two prisons, at Trenton, New Jersey and Cherry Hill, Pennsylvania, then under the separate or Philadelphia system of prison discipline, they concluded that confinement there produced

insanity "from the admitted direful effects of unmitigated solitude." The Auburn prison, though, was given a clean but not spotless bill of health as it neither sufficiently stresed moral reform nor was its general discipline relaxed enough.[59] But the silence on the proclivity of this prison to produce insanity speaks for itself; to the Commissioners a prison properly run on the congregate or Auburn system would be a healthy mental environment, punitive, of course, but not conducive to insanity.

It seems fair, then, to infer that the Commissioners believed the cases of insanity which they had examined were basically all due to the harsh treatment which these convicts had received under the autocratic regime of Warden Smith. Yet to leave off the subject at this point begs a question. Notwithstanding the doctoring of the punishment records in the cases of Brown and Reveille, there was a wide ground separating the fundamental viewpoints on criminal insanity held by the main participants in the dispute over these two cases. This variance of opinion suggests that this dispute occurred at a period when the existence of a criminal lunatic class was nearing acceptance by the public, reinforced by the opinions of a medical elite, the alienists, who were striving to gain professional standing in the eyes of the law and of the public.[60] The incessant flogging of convicts like Brown now became morally reprehensible. As the shocked Commissioners decried in his case, "Thirty-five times this man has been subject to the torture of the cats."[61] One of the Inspectors, though, could only see him as a "most hardened offender...an obstinate man of low intellect."[62] Furthermore, instead of simply being outrages against humanity, as a number of authors have portrayed the punishment of insane convicts, their treatment should probably be viewed as normal events which took place in the context of the autocratic regime of Warden Smith.[63] Otherwise the controversy over the sanity of Brown and Reveille, an important catalyst in spurring on the Government to investigate the irregular state of affairs at the penitentiary, would not have so bitterly divided the prison staff.

After the Commission of Inquiry had ousted the regime of Warden Smith from the penitentiary in November 1848, including the Board of Inspectors in the purge, the management of insane convicts still had to be contended with. Evidently the Government chose for the moment not to send any more insane convicts to the Provincial Lunatic Asylum, apart from one female convict whose sentence had expired late in 1850 and whom the prison authorities considered incapable of looking after herself outside the prison.[64] Without a proper place in the prison to confine lunatics, they were instead housed in cells separate from the other convicts or in the temporary hospital. But despite this policy of isolation there was, according to the new Warden D.AE. Macdonell, "no remote place of security in which they can be kept from disturbing the other prisoners, and their unruly conduct is enough to show the other convicts how easy it is to cause trouble in the prison."[65] The Board of Inspectors and the Surgeon therefore insistently began to call upon the Government for the transfer of these prisoners to the Provincial Lunatic Asylum. In calling in 1850 and 1851 for legislation (ostensibly to eliminate the necessity of granting a free pardon in each case) to empower the prison authorities to remove insane convicts to the asylum, the Inspectors argued that the ordinary confinement of these convicts was in almost all cases certain to add to their insanity.[66] The Surgeon was of the same opinion, stating in 1849 that the "proper moral management" of these convicts could not be carried out at the penitentiary. He considered the asylum to be the proper place for them, "where all the necessary appliances are in the hands of persons [i.e. alienists] trained in the management of this affliction in all its forms."[67]

Doctor Sampson certainly had good reason to desire insane convicts be removed as quickly as possible from the penitentiary, especially as they posed a suicide threat. On October 26, 1847, a convict committed the first suicide at

the institution, "by inflicting a wound on his left arm and hanging himself by the neck with a cord while in a state of insanity," according to the Coroner's verdict. He had been certified insane by the Surgeon on September 3rd, after having come to the latter's attention because he had stabbed a keeper on August 28th. On September 4th Warden Smith duly wrote to the Government, requesting its advice on the matter. Yet the letter sat unanswered, due to the temporary absence of the Attorney-General of Canada West, until after the Warden had informed the Government of the melancholy death of the convict.[68] This episode provided clear evidence of the latent problem of delays in petitioning the Government for the removal of these convicts from the penitentiary.

Moreover, it was revealed at the Coroner's Inquest that Dr. Sampson had not seen the convict between the time he certified him insane and the time of the latter's death. Consequently the Board of Inspectors took the precaution to avoid a repetition of the suicide by ordering the Surgeon to examine daily all insane convicts until they were cured or removed from the prison by order of the Government.[69]

The requested legislative relief came in August 1851 as part of a new Penitentiary Act, which embodied most of the recommendations of the Commission of Inquiry. Provision now existed for a convict to be removed to the provincial Lunatic Asylum at Toronto, having first been certified insane by a three-man Medical Board appointed by the government.[70] This body was constituted of local physicians, with Dr. Sampson as its chairman.[71] It was periodically called into session when a convict was suspected of being insane. The Board reported its finding, through the Warden, to the Government, who would then issue a Governor-General's warrant commanding the Medical Superintendent of the Provincial Lunatic Asylum to receive the convict which the Warden of the Penitentiary was empowered to send to him. The convict would remain at the

asylum until his sentence expired, unless he was then still insane in which case he would remain there. If the convict "recovered his reason" while there he was to be returned to the penitentiary to finish his sentence.[72] This option was soon exercised, in late November of 1851. Seven convicts were then sent off to the asylum, among them James Brown.[73]

While this legislative action tacitly acknowledged that insane convicts were not fit subjects for the penitentiary with its strict regimen, at the same time it was seen that these convicts might be cured of their illness and returned to the penitentiary. This attitude stood in sharp contrast to the general view taken previously by the Warden and others at the prison, suspecting any convicts manifesting signs of insanity to be malingering. But once these convicts were routinely removed from the prison experience would prove that the Provincial Lunatic Asylum was not suited to their care either, a development which contributed to the founding of the Criminal Insane Asylum at Rockwood in 1856. By 1851 lunatic convicts had thus become a separate class of convicts, rather than being a rarity in "a Prison well conducted" as earlier stated by William Powers. And, not insignficantly, the need to delegate to a medical board the certification of the insanity of convicts demonstrated a reliance on the professional expertise of the medical community.

Chapter Six

Controversy Over "Moral Monsters" And The Rockwood Asylum: The Insane At The Penitentiary, 1851-1865

Once the authorities at the Kingston Penitentiary were empowered by law in 1851 to send convicts medically certified as insane off to the Provincial Lunatic Asylum at Toronto they likely thought their problems in managing this class of convicts would be greatly diminished. Events, however, would prove differently. Within five years a number of factors arose to pressure the Government of the Province of Canada West to open a separate asylum for the criminally insane. The evidently new practice of commuting the capital sentences of insane criminals to life imprisonment and the inadequacy of the asylum for the confinement of lunatic convicts, combined with severe overcrowding at the penitentiary by 1855, strongly contributed to the founding in 1856 of the Criminal Insane Asylum at nearby Rockwood. There a custodial duty to society was ostensibly reconciled to the medical goal of curing insanity.

Central to the pressures leading to the building of the Rockwood Asylum was the new practice of confining insane criminals to the prison. Guilty of capital crimes, mostly murder, these offenders had their sentences commuted to life imprisonment in the penitentiary.[1] Unfit for punishment because they could not be held accountable for their acts, these often violent convicts posed critical problems to the discipline of the prison. The first of this group, the murderer John Jones, was sent there in November, 1848, with instructions from the Government of place him "apart from the herd of convicts". Suffering from dementia, Jones was quickly found incapable of manual labour. As a result he was placed in the prison hospital.[2] Another murderer, Christian Geintner, was received in June 1849. During his confinement he displayed a violent dispositon, threatening to assault anyone who came near him as he was under the delusion that

he was about to be taken to the gallows. This delusion likely caused him on one occasion to wound two convicts.[3] A third murderer, Thomas Therien, came to the prison in November 1852. This convict worried the prison authorities by once fasting for twenty-seven days and also by his unpredictable behaviour. The latter caused the guards and keepers "to be particularly guarded from any sudden movement on his part."[4]

Not surprisingly, the prison authorities chose to rid themselves of these particularly troublesome convicts by sending them off to the Provincial Lunatic Asylum. Jones and Geintner were removed there in December, 1851 and Therien followed in July 1853. But events soon proved that this was not at all an easy disciplinary solution for the prison authorities. Trouble began anew when these convicts were returned from the asylum late in 1853. Instead of being cured they were quickly found to be still deranged. Only the condition of Jones was deemed slightly improved, and even then he attempted to commit suicide by cutting his throat.[5] Because of the reluctance of the Government to hang such criminals, the chronic insane were now perforce being added to the ranks of insane convicts, complicating the management of this class. By 1856 five such prisoners would be housed in the penitentiary and free from the hangman's taut noose.[6]

But Joseph Workman, the Medical Superintendent of the Provincial Lunatic Asylum, was very sure that the three convicts in question were sane. When he sent Jones and Therien back to the penitentiary in July 1853 he reported to the Government on the two cases. Both Workman and his predecessor, John Scott, believed Jones was an impostor who had never been insane. Workman stressed that he was "a most dangerous inmate of a building so imperfectly constructed for the safekeeping of persons of his character."[7] He held a similar view of Therien.

> The Character given this man by the warden of the Penitentiary, was so bad, as to give me serious apprehensions respecting the safety of the patients confined in the same ward with him. I

> deemed it expedient to have him treated with mildness, but closely watched by the Keepers. I believe he was not insane when he entered the asylum; and I have detected him in some imposture, which have [sic] left little doubt on my mind that the Penitentiary is his most appropriate place of confinement.[8]

It was Geintner, though, who proved the most troublesome to Workman. In September, 1853 he reported to the Government that the convict was sane. He had not sent him back to the penitentiary in July, also with Jones, Therien, and five other convicts, because it seemed the convict was not fully cured. But soon after that a disturbing incident took place. Late in August an asylum inmate died and the death was blamed on Geintner. Workman had numerous interviews with Geintner about the episode. He found him fully sane, with "a degree of ingenuity in his exculpatory explanations" which he believed no lunatic was capable of.[9] And the asylum head again stressed the unsuitability of his institution for such persons. However, he now focussed on the crux of the matter: the fact these convicts were not hung for their crimes had long-term consequences.

> If the propensity to commit murder is to be held by juries as a form of insanity exempting the parties from legal accountability, it must certainly be necessary to provide for such persons more suitable place of confinement than our modern lunatic asylums. Successful treatment of simple insanity must be totally impracticable in any house constructed as a prison.[10]

Furthermore, Workman also took the occasion to inform the Government just how bad a problem insane convicts and county gaol lunatics were for the asylum. It was clearly very difficult to manage this group.

> Two wards in this asylum in which the penitentiary and jail lunatics are lodged among other patients, have become notorious in the establishment for their disquietude, and the comparative incurability of the inmates; whilst they are altogether unsafe as places of confinement for criminals; and I find it impossible by any amount of vigilance to prevent frequent quarrels and the infliction of bodily injuries to say nothing of the incessant uproar and profanity at all times prevailing.[11]

On the occasion of his first annual report in 1854 Workman again angrily castigated the practice of sending insane convicts to the asylum. He argued that there was a moral distinction between these criminals and the other asylum inmates. To Workman they had the status of convicts rather than madmen. As T.E. Brown points out,

> Workman deplored this practice as "an evil of inconceivable magnitude,...an outrage against public benevolence and an indignity to human affliction." The presence of these "moral monsters in the same house of refuge with the harmless, feeble, and kind-hearted an truthful victims of ordinary insanity" made it "impossible to preserve that salutary discipline and mild management which are indispensable to the successful operation of the institution."[12]

Workman, it should be pointed out, was not alone among alienists in decrying the transfer of the criminally insane to asylums. Gerald Grob has noted that this class of patient proved especially troubling to American asylum superintendents, likewise not only swelling the ranks of the chronic insane but also requiring these institutions to have separate maximum security facilities. And these alienists believed the asylum was not epuipped to perform the latter task.[13]

While Workman was no doubt certain about the sanity of the convicts he had returned to the penitentiary, and of course relieved at their removal, the penitentiary authorities must have been displeased when they found Jones and Therien still insane. And their ire must have been compounded when Geintner later returned in the same state of mind. Evidently unsure about how to proceed here, they asked the Government for instructions about the care of Jones and Therien. On September 9, 1853 Warden Macdonell, at the behest of the Board of Inspectors, wrote to Pierre Chaveau, the Solicitor-General for Canada East, in order to forward to him a certificate from Dr. Sampson stating that both convicts were quite insane. The Warden also informed Chaveau in precise terms that the penitentiary was not a proper place for such persons. It was designed as a

secure and punitive place for convicts, and lacked separate housing for lunatics. Macdonell stressed that it took just one convict, in this case Therien, to subvert the "quiet and good order" essential to the prison. And he also pointed out that these convicts, not responsible for their acts, could not be disciplined for violating the prison rules. The Warden therefore suggested that Therien especially should be returned to the Provincial Lunatic Asylum "where he could be treated as a lunatic."[14]

This request sat unanswered by the Government until March 1855, when it announced the establishment of an asylum for criminal lunatics.[15] Nonetheless on September 17, 1853 it did sanction the return of the convict Geintner from the asylum to the penitentiary.[16] Still unsure that November about the proper management of these convicts, the Inspectors then petitioned to the Governor General of the Canadas for instructions. As they pointed out, the return of these convicts, who were still insane, violated the 1851 statute which governed their transfer to and from the asylum. The Inspectors wished to know if the practice was to be ceased, in which case proper accommodation would be made for them in the prison. But if the status quo was to be preserved, they requested that the asylum authorities be ordered not to return covicts who were de facto insane. The Inspectors justifiably pointed out there was heavy cost to sending covicts to and from the asylum without any advantage to the penitentiary.[17]

Apparently the response of the Government to the query of the penitentiary Inspectors was to keep the insane convicts at the penitentiary, for no more were sent to the asylum.[18] Moreover, the Inspectors suggested in their annual report for 1853 that a change in practice might be made. Citing the protests over the dispatch of Lower Canada convicts to the asylum and also the "considerable inconvenience and expense" in sending convicts to and from there, they argued that these cases could be well-managed within the prison. While admitting alienists had now made a specialty out of the treatment of mental illness, they

believed that Dr. Sampson, "the regular bred Physician," was very capable of treating insane convicts. In this context the Inspectors now used part of the lower story of the new hospital as a suitable retreat for those lunatics whom it was unsafe to let at large in the prison.[19]

Dr. Sampson, though, was not so obviously pleased with the change. After discussing the cases of Geintner, Jones, and Therien in his annual report for that same year, he rhetorically posed a serious ethical question. Since these convicts had their capital sentences commuted, he noted that "here a question arises which it is not my province to discuss, namely, whether persons labouring under such an influence, and deemed undeserving of the Primary Punishment because of their unaccountability, as moral agents, should be subject to a secondary one." Clearly Dr. Sampson disagreed with the decision of the Inspectors, an opinion he further implied by stating that few cures would take place if the statutory provision for the removal of the insane convicts to the asylum was repealed (as was apparently being considered). Moreover, to Dr. Sampson the treatment of the insane required the special expertise of "Medical Officers well trained, by preliminary Education, for their important vocation, acquainted with the Philosophy of the human mind, and fitted by the character of the heart, as well as by their intellect."[20] The Surgeon thus seems to have seen the lunatic convicts as much more deserving of medical care than of custodial care. In doing so he was also implicity arguing in support of medical professionalization and specialization.

But by the end of 1854 the Inspectors had again changed their tune about the adequacy of the prison for confining lunatic convicts. In their unpublished annual report for the year they believed it incumbent on them to state the prison was "a place most unsuitable for Lunatics." Experience had again proven that neither the prison ranges nor its hospital were proper locales for the "ravings" of insane convicts. In the ranges these disturbances had "a bad effect upon the

strict discipline that is necessary to be kept up during the night," while in the hospital "the same objection exists on a higher degree for their ravings disturb the Sick and dying." As well the Inspectors noted the keepers and guards lacked the expertise possessed by those "who have had experience and who have devoted a length of time and study to that subject."

At the same time the Inspectors now addressed the ethical question Doctor Sampson had quietly raised a year earlier. They agreed with him that the convicts returned from the asylum to the penitentiary but still insane had been so when they committed the offense they were guilty of and had remained deranged. The Inspectors therefore urged that such convicts suspected of insanity be subject to "judicious investigations" before they were sentenced, presumably avoiding the necessity of burdening the prison authorities with their care. They no doubt implied these especially onerous lunatics were better off at the Provincial Asylum. Careful examination, would also serve to ferret out those "artful Criminals" who, as the Inspectors were well aware, feigned insanity "to evade the penalty of the law."[21]

Yet the strong complaints of the Inspectors about the presence of insane convicts in the penitentiary fell on deaf ears, likely because the government had already firmly decided to the contrary by early March of 1855. Instead the Government followed a course of action advocated by John A. Macdonald, the Attorney General for Canada West.

> As that portion of the Provincial Penitentiary lately occupied as a military prison has been given up by the military authorities and is now unoccupied, it could easily be fitted up for the reception of the criminal lunatics in the asylum, now 21 in number, as well as those at present confined in several county gaols of Upper Canada.[22]

With the opening of the new prison asylum an appropriate facility was now available, answering the vocal protests of both the penitentiary and the asylum authorities.

To superintend the new asylum the ministry of Augustin-Norbert Morin and Allan Napier McNab appointed John Palmer Litchfield, a journalist, physician, and Professor of Medicine at Queen's College.[23] Apparently, the locale within the prison walls was to be only a temporary one for, as Macdonald had insisted, the crowded penitentiary would soon require the space because of the increasing number of convicts. He therefore suggested a permanent asylum for insane criminals be constructed on the penitentiary farm, outside the walls of the institution.[24] Upon learning of this decision Warden Macdonell proceeded to secure the approval of the Government to substitute the West Wing of the prison instead for the accommodation of insane convicts. He considered this area better suited for the purpose since it was more removed from the other convicts. Also its larger size enabled all the insane convicts to be placed in one section of the institution. Renovations were subsequently carried out to divide the two tiers occupied by the lunatics off from those housing other convicts.[25] With these arrangements complete lunatic convicts and those from the asylum and county gaols started filling up the prison in June 1855.[26]

Having rid the Provincial Asylum of these "moral monsters," Joseph Workman probably breathed a welcome sigh of relief. Female convict lunatics, though, will remained there until at least late 1856 because the prison could not adequately house them.[27] At the penitentiary there continued to be a division of opinion about the presence of lunatic convicts. In his report for 1855 Dr. Sampson was certainly pleased his call had been heard for a separate locale for insane convicts. He stated "it is with great satisfaction that I now see a separate establishment lately formed for the management and safe keeping of that unfortunate class of individual, and conducted by a gentleman qualified by experience for such an undertaking to whose care the several cases of lunacy then in the prison were transferred."[28] Yet the Inspectors continued to remain opposed to the presence of these convicts, calling for their expeditious removal

by the Government. They strongly pointed out the penitentiary was almost filled to its maximum capacity, and would be so within six months if the influx of convicts did not abate. And again they cited the disruptive "great noise" frequently made by the lunatics. The financing of the prison asylum also piqued the Inspectors. By order of the Government such items as clothing, bedding, rations, and firewood had been charged to the penitentiary, sizeable costs which had "no right to be included in the expense of the Provincial Penitentiary."[29]

The noise of the lunatic convicts and the expense of their upkeep were inconveniences which could, it seems, be tolerated at the prison. Nonetheless the attitude of the Inspectors towards this continuing problem points to the fact the lunatics were squarely seen as madmen, lacking the status and rights of the other convicts. It was obviously unjust, they believed, for the convict who had submitted without protest to the strict discipline of the prison also to have to endure the noise of the lunatics and the consequent loss of his sleep after had been at hard labour all day.[30] However, what could not be tolerated indefinitely was the overcrowding of the institution in the mid-1850s. If the convicts had to share cells it would undermine the silence essential to the disciplinary routine of the Auburn system prison.[31] Pressure thus gradually mounted for the quarters of the lunatic convicts to be fireed up to meet the influx of convicts. If there was a flaw in the decision to set up a criminal insane asylum within the prison walls, then surely this was it. The short-sighted convenience of the solution appears to symbolize the Government's neglect of this group, for it effectively put the burden of their care on the penitentiary authorities. And the prison consequently experienced, as the Warden aptly wrote in his Daily Journal, a "peculiar emergency" as the institution became increasingly overcrowded.[32]

The shortage of space at the prison reached crisis proportions late in 1856. With over six hundred convicts there every cell was occupied and some newly-arrived convicts were placed in one of the two tiers in the prison asylum.

As well, some of the hospital cells were pressed into service until cells in the ranges were vacated by convicts whose sentences had expired. In the face of this crisis a strongly reluctant Dr. Litchfield was compelled to remove the lunatic convicts from the West Wing to the damp and poorly ventilated basement of the prison dining hall. Unspecified plans had been made to transfer this group of convicts elsewhere, evidently to another locale in Kingston. However, the Inspectors noted that the "Contemplated arrangements" were not completed.[33] In being shoved off to this dungeon the lunatics were suffering fully from their low status at the prison, categorized by the Inspectors as madmen first and convicts second but confined in an institution not designed for their care.

The concerned provincial government did take action in October 1856 to remedy this "peculiar emergency," but it was of limited immediate use. The purchase of the Cartwright estate, known as 'Rockwood' and not far from the penitentiary, provided a house, stables, and thirty-five acres of land for an asylum site. In the meantime, the stables were converted into a temporary asylum for female lunatics. Three years elapsed before construction was begun on the permanent asylum, which was largely built with convict labour and completed in 1864.[34] Understandably, the Inspectors were quick to praise the acquisition of the Cartwright estate. They were eminently satisfied with "the kind, attentive, and scientific treatment of the insane under Dr. Litchfield's care," but they stressed that the number of lunatic convicts was large and bound to increase. With both the Canada East and Canada West asylums seriously overcrowded, they believed it their duty to recommend to the Government that it not postpone providing "suitable retreats for the insane."[35] In this context they waxed eloquently on the benefits soon to be brought by the new asylum:

> In such an abode not only could their natural wants be administered to, but their mental malady receive kind and adequate treatment, but means of which a temporary derangement may often be cured, and the subjects restored

> to their family, sound in body and mind: whereas, by being permitted to remain in unrestrained liberty they become most dangerous subjects, requiring compulsory confinement in Gaols or Asylums, and thus entailing an immense cost upon the country, while the chances of recovery are correspondingly diminished.[36]

While the Inspectors evinced some doubt that the high cure rate propounded by one unnamed alienist, of from seventy-five to ninety percent, was unattainable, they were nonetheless sure "early and proper attention" to these cases would provide economic benefit as well as the obvious moral benefit to the community at large. They also advised that the asylum would not be an easy alternative to the penitentiary. The often clever attempts by convicts to feign madness would be carefully guarded against and duly rigorously punished. All in all, the Inspectors considered the new asylum would advance the "best interests of society."[37] By the end of 1857 thirty-six lunatics were housed there, two-thirds of whom were not convicts.[38] The latter group comprised insane persons who had been convicted of a crime, or persons acquitted of a crime for reasons of insanity.[39]

Yet in practice the sanguine rhetoric of the Inspectors and the Surgeon proved to fall very much short of its promise. Until 1865 the male lunatics remained in the dining hall basement, except for a group of twenty-one patients who were transferred in 1862 to a small part of the new building at Rockwood. The removal "of the most docile of the insane" served to prevent further over-crowding of the basement asylum.[40] It was a far from satisfactory arrangement for the lunatics at the penitentiary. The comments of the Inspectors were frank and graphic about this appalling situation. On one visit to the place in December 1858, at Dr. Litchfield's request, they found it overcrowded and approved that the latter suggest to the Government that it transfer the lunatic convicts elsewhere.[41] Forty-seven lunatics were then confined in cells there, thirty-two of which were not convicts.[42] The Inspectors returned there two

months later and again found it overcrowded but so unhealthy that even the guards, too, were suffering from the irreparable "raw and fetid" atmosphere of the basement.[43] The Inspectors found the situation even worse in early April of 1859, describing it as "in no ways suited for the residence, even for a brief period, of human beings." And Dr. Litchfield was alarmed that the convicts were daily getting weaker, fearing that despite his best efforts they would die from the want of proper conditions.[44] It was clearly a grim picture to all concerned.

Remedial action was undertaken in 1859 to improve the lot of the asylum patients, but the measures seem to have been somewhat cosmetic. The drainage of the dining hall was ordered improved so as to prevent not only water from seeping into the basement but also "the noxious vapours that arise from the Stagnant water."[45] The other measure was the decision of the Government in August to undertake immediate construction of the Lunatic Asylum at Rockwood. The condition of the prison asylum must have figured in this decision, but probably more important was the great number of unoccupied convicts made available by the non-renewal of labour contracts. But just as the Inspectors feared, the asylum took many years to be fully completed, with construction only finished in 1864.[46]

In the interim before the male lunatics were transferred to the new asylum in 1865 conditions in the prison asylum remained poor. Certainly the increase of convicts housed there from fifty-nine in 1859 to sixty-four in 1860 did not help matters, requiring drastic alterations. Sleeping bunks had to be put up along the sides of the day rooms, an arrangement which was viewed as entailing considerable risk to the security of the patients. But as Dr. Litchfield had warned earlier, the health of his patients suffered from the physical enviornment, a cause to which he attributed several deaths. Significantly, the mortality of male convicts declined from 9.01 percent in 1864 to 1.5 percent in 1865 when all the patients had been transferred to the new asylum. And, as

Dr. Litchfield pointed out, the deaths in the former year had occurred among those confined to the prison asylum for "successive years."[47]

At the time the new asylum opened at Rockwood its virtues for the treatment of insanity were heralded. In particular its scenic location overlooking Lake Ontario was believed to be ideal for easing the disturbed mind. But over the next two decades, as Catherine Sims has shown in her important study of this institution, the grossly inadequate ventilation and heating of the building were stumbling blocks to the treatment of the patients. The necessity of the physical well-being of the patients was outweighed by the reluctance of various governmental authorities to offer adequate financial assistance to the institution. The care and treatment of the criminally insane both before and after the opening of the new asylum in 1864 was thus, as Sims rightly concludes of the period from 1856-1885, "simply not a fundamental concern of any level of government."[48] Like other asylums opened with so much optimism about the cure of the insane in the mid-nineteenth century, the Rockwood asylum ended up more or less performing only a custodial function.[49]

Nonetheless, it is worth remembering that the Rockwood Asylum was regarded as a progressive development for its time. It attracted the attention of the noted American penologists E.C. Wines and Theodore Dwight, whose valuable survey of American and Canadian penitentiaries and reformatories was published in 1867. The authors paid particular note to the treatment of the criminally insane, considering this a "question of grave importance." They praised the Rockwood Asylum and a similar institution in New York State as the "best arrangement for their [i.e. the criminally insane] disposal." They pointed out the majority of states did not provide "large and admirably arranged asylums" for these "unfortunates." Instead the criminally insane were retained in prisons to their own detriment and to the resentful inconvenience of prison authorities. A few states did send what few insane convicts there were to one of the state lunatic

hospitals.[50] Massachusetts, for example, started following this practice in 1832.[51] In England, though, the passing of the Criminal Lunatics Act in 1860 provided for the construction of a new institution where custodial duty was to be reconciled with medical goals. The opening of Broadmoor in 1863 replaced the criminal wings at the Bethelehem Asylum, a gloomy place fulfilling only a custodial function.[52]

With the opening of the basement asylum in the mid-1850s the Kingston Penitentiary authorities had basically solved the long-term problems they faced in the management of insane convicts. Out of their hands, though literally not out of earshot, the lunatics had been effectively removed from the convict population. Nonetheless the continuing problem remained of convicts who feigned insanity with great effort and whose deception was a difficult but exigent task for the prison authorities to expose. Some convicts could act the madman with very disturbing ingenuity.[53] Warden Macdonell privately regretted he had to punish such convicts, but the discipline of the institution had to be maintained. After lashing one of these convicts he wrote in his Daily Journal that, "These attempts must be kept down otherwise we will be overcome with acting Madmen."[54] At the same time he was lenient in inflicting punishments where such convicts promised good behaviour in the future.[55] And, of course, convicts continued to become insane at the penitentiary, so it was difficult to deal with convicts, who perhaps in fact insane, would not submit to the discipline of the institution despite verbal warnings and corporal punishments.[56] Nonetheless in some instances the deception was very clear cut, as in the case of a determined convict who had feigned insanity at the Auburn Penitentiary. He was then sent to an asylum, from which he escaped to Canada where criminal acts soon landed him in the Kington Penitentiary.[57]

Aside from the disciplinary problem of convicts feigning insanity, by the late 1850s the penitentiary authorities had adequate means to deal with the

difficulties posed by insane convicts. Once such convicts were dispatched to the prison asylum they no longer posed any serious problems to the institution. Of no positive economic value, due to overcrowding they were shuffled off from adequate quarters to a relatively remote part of the prison. The lowly status they had was reflected in their dungeon-like abode, deficient in proper living conditions and dangerously unhealthy. Indeed, one wonders how many convicts sent there remained until death. And the Government was content to let the more than fifty convicts there languish until the Rockwood Asylum was ready for their reception in 1865. One also wonders if the conditions at the prison asylum were in fact tacitly tolerated by the prison authorities, serving as an obvious deterrent to those convicts who by feigning insanity sought relief from the hard labour of the penitentiary.

Another indication that the penitentiary authorities had learned how to cope with the problems posed by insane convicts was the passing of a new regulation in 1856. It stipulated how the Surgeon would deal with these cases.

> In all cases of insanity, or threatened insanity, the Physician will institute a searching enquiry into the Convict's situation, as to age and temperament, as well as endeavor to ascertain if insanity has prevailed in his or her family, if naturally or on a average of a strong or weak intellect, or has been exposed to any particular injury or privation, or if his or her habits were of a nature to predispose or induce mental aberration, as well as into such other circumstances as may tend to explain or elucidate the nature of the case. And when an insane convict shall be transferred to the Asylum <u>at Toronto</u>, the Physician shall send a report as above for the information of the Surgeon of the Asylum.[58]

Throughout the period from the opening of the penitentiary until the founding of the Rockwood Asylum the treatment of insane convicts by the prison authorities changed from an apparent refusal to acknowledge such cases, to heated medico-legal disputes over their sanity, and to a custodially-oriented view mixed with the recognition of the need for medical treatment. But custodialism characterized the treatment of the insane over the next few decades at the

Rockwood Asylum, as attempts at medical treatment were hindered by inadequate financial support for the institution. Medical treatment again remained wholly subordinate to the overarching need for penal discipline.

Chapter Seven

Epilogue

To have been a convict at the Kingston Penitentiary during the pre-Confederation era must have been an unattractive but not a terribly unhealthy experience. Fatal contagions did strike within the walls of the prison, but they did not cause many deaths. An often poor diet as well as inadequate heating and ventilation must have to some degree affected all convicts but probably were not seriously debilitating to their health. Similarly, the various punishments for infractions of the prison discipline likely were only marginally harmful to the general health of the convicts. But during the regime of Warden Smith some cases of mental derangement were exacerbated by severe means of punishment while a few convicts were perhaps hastened on their route to insanity by it. Insane convicts certainly did not fare well throughout this period. At first they were usually regarded as feigning insanity and were punished harshly. More enlightened attitudes prevailed after the removal of the regime of Warden Smith. Yet over the next several decades the Government failed to provide adequate facilities for the confinement and treatment of this separate class of prisoners.

Nevertheless convicts did receive good medical treatment from the prison doctor. But that care should be put in context with the ambivalent role of the physician as doctor versus disciplinarian. Dr. Sampson was clearly a man in the middle, caught between advocating the proper care of his patients and serving the best interests of the institution. It was he, for example, who had to judge whether a convict complaining of illness was in fact sick. He could not afford to be lax in such cases for malingering would then swell the Sick List to unmanageable proportions. Yet the prison doctor could cope with this unending problem. In contrast, it was the events surrounding the administrative breakdown at the penitentiary in 1848 which truly showed how ambiguous the postition of the prison doctor was, particularly in his dispute with the Warden and the Board of

Inspectors over the insanity of the two convicts. Fortunately for Dr. Sampson the Government wholeheartedly affirmed his judgement, stating, importantly, that the professional expertise of the doctor entitled him to make medical decisions independent of the approval of other prison officers. But health care at the penitentiary remained subordinate, albeit not totally, to the discipline of the insititution.

At this point one also needs to ask why health care at the penitentiary was a concern at all. Previously it seems to have mattered very little, apart from an anxiety over contagions spreading from the pestilence-ridden prison to the community. The answer appears to be that a new form of social discipline had emerged in the industrializing early nineteenth century, one in which criminal man was no longer seen as being in a timeless state of wickedness and sin. Now the criminal was assumed to possess reason, a quality which could enable society to transform him, through the mechanism of the penitentiary, into a worthy citizen.[1] Proper health care was therefore seen as important by the prison reformers of the early nineteenth century because their faith in human improvement through social and environmental manipulation could not be realized in an unhealthy and decrepit setting. Indeed, the logic of prison reform demanded it. If prisoners were to be taught compliance to the law through a psychological punishment they had to be convinced it was a humane one, free of the degrading corporal punishments and poor gaol conditions of the past.[2]

Prison reformers therefore believed that a 'humane' form of punishment was more effective than resorting to a 'bloody code' of justice. Nonetheless, one must ask whether this new philosophy of punishment was entirely admirable for the 'humane' qualitites it possessed. To leave the question unanswered would be equal to tacit uncritical acceptance of the benevolent motives of prison reformers in creating the phenomenon of the penitentiary. It can certainly be said in the case of the Kingston Penitentiary that a strong sense of charity

characterized the provision of medical services, particularly on the part of the prison doctor. At the same time health care was tempered by a solid commitment to maintaining the discipline of the prison; convicts, after all, had been put there specifically in order to be punished. Yet the prison reformers had unwittingly created a leviathan, which has been inherited by many generations after them. Their ideas about the penitentiary morally reforming the convict fell by the wayside but the high and gaunt stone walls remained in use for they did effectively remove criminals from society. And by the 1850s and 1860s prisons were becoming overcrowded, with custodialism the dominant penal doctrine.[3] The result was an ideological inertia surrounding these institutions, though attitudes towards crime and punishment may have changed in the outside society. The answer, then, to the question raised above seems to be that the humaneness of the reformist ideology at issue here was genuine, but that its historical moment simply came and went within a couple of generations. And, of course, it was by no means easy at the time to implement this ideology, as the corruption of Warden Smith's regime at the Kingston Penitentiary bears witness to.

Over the next seventy-five years after Confederation in 1867 penitentiary medical services would also be characterized by inertia, lagging behind developments in medicine in the outside society and with its institutional priority very much unchanged. Nor would the role of the physician and his nursing staff change much either over these decades. Also some of the same medical problems encountered at the pre-Confederation Kingston Penitentiary would reappear later in the nineteenth century and then in the twentieth century. And throughout the conflict faced by penitentiary health care staff of being both healers and disicplinarians has remained, just as much in 1983 as in 1835.

Introduction

For over thirty years the Kingston Penitentiary functioned as a provincial prison, first for Upper Canada and then, from 1841, for Lower Canada as well. But with the advent of Confederation in 1867 the nation building of the new dominion also meant the creation of a federal penitentiary system. The British North America Act (1867) established and defined federal and provincial responsiblities for criminal justice. Penitentiary sentences were to be two years or more in length, with those serving lesser terms going to provincial prisons or reformatories.[1] With the passage of the first Penitentiary Act in 1868, the new system comprised the Kingston Penitentiary (with the Criminal Lunatic Asylum at Rockwood attached to it), the Halifax Penitentiary, and the St. John Penitentiary.[2] At the end of 1868 these prisons held 852, 54, and 107 prisoners respectively.[3] Yet in reality the latter two institutions were little more than colonial jails.[4] They were a far cry from their Kingston counterpart, whose rigid penal regimen was based on the widely-used Auburn system of prison discipline. As a result they were soon replaced by a new penitentiary at Dorchester, New Brunswick in 1880.

The Dorchester Penitentiary was just one part of a wave of penitentiary construction across Canada in the two decades after Confederation. This building program was not motivated by any particular belief in regionalism, but was more an acknowledgement of the difficulty of safely transporting prisoners across the country.[5] The first new institution was the St. Vincent de Paul Penitentiary, now known as the Laval Institution. Converted from an old reformatory, it was opened near Montreal in 1873. In Manitoba the old Hudson's Bay Company jail at Fort Garry was replaced in 1877, after six years of federal use, by the Manitoba Penitentiary (now Stony Mountain Institution) at Stony Mountain. A year later the British Columbia Penitentiary was opened at New Westminister. Two more institutions opened before the first World War in 1914, completing this flurry of

penal construction: at Edmonton, Alberta in 1906 (it would be closed in 1920) and at Prince Albert, Saskatchewan in 1911.[6] Not until the 1960s would the Canadian penitentiary system again expand so greatly.

New ideas in penology did not characterize these post-Confederation prisons. Instead, in design, administration, and purpose they were all modelled after the Kingston Penitentiary. It outdid the others in size, function, and ambition. At the end of June 1887, for example, its convict population was 526. In comparison, St. Vincent de Paul, Manitoba, British Columbia, and Dorchester had 280, 82, 89, and 158 convicts respectively.[7] Also based on practice at the Kingston Penitentiary were the official Penitentiary Regulations, which were revised three times--in 1870, 1888, and 1899--before the first World War.[8]

The format of the administrative control over the penitentiary system changed only once in the pre-1914 period. At first the pre-Confederation practice was followed, of having a Board of Directors reporting to the Governor General. In 1875 the Penitentiary Act was revised, and this body was replaced by an Inspector of Penitentiaries. He reported to the Minister of Justice, who in turn was responsible to Parliament. J.G. Moylan, Secretary to the former Board of Directors, occupied the new post until his retirement in 1895.[9] He was then succeeded by Douglas Stewart, who served until his retirement in 1918. Stewart was aided in his work by the appointment in 1902 of an Assistant Inspector of Penitentiaries.[10] The practice of an inspectorate continued until 1918, when the Penitentiary Act was revised and a Superintendent of Penitentiaries instead held this post.[11]

While the penitentiaries across the country were subject to centralized control over their administration (especially regarding their budgets which had to be voted by Parliament), they were, in fact, for much of this era subordinate to the ever-present demands of local political patronage. Only by the turn of the century did this situation begin to change, as part of a general social trend

to improve the running of society according to the criterion of efficiency.[12] In 1901 Douglas Stewart told a conference of his wardens that at the start of his term the penitentiaries were regional, not national institutions.

> The several penitentiaries were not treated as Dominion institutions, nor even as provincial prisons, but each as a municipal institution operated financially and officially for the benefit of the locality in which it was situated. Judges and magistrates frequently sentence a prisoner to serve a term in the "Provincial Penitentiary", although, for several decades past, no such institutions have existed. The local advisors of the Government took even a less comprehensive view, and insisted that all supplies for the prison should be purchased from local tradesman, and that no appointments should be made except in accordance with the political exigencies of the locality. This misconception of the real character of the institutions is, in my opinion, the germ to which nearly all scandals and deficiencies of penitentiary management can be traced, and so long as it exists it is useless to hope for the ideal administration which should characterize the penal management of a country.[13]

Inefficiency was thus the chief result of Canadian penitentiaries being used as sinks of patronage. In 1897 a Commission of Inquiry investigating the state of affairs at the Kingston Penitentiary reported that "waste and extravagance" prevailed in every department of the institution.[14] Patronage, too affected the provision of medical care to convicts, albeit somewhat indirectly. In 1871, Sir John A. Macdonald, then Prime Minister, had successfully favoured a local physician by fending off the other applicants for the surgeonship of the Kingston Penitentiary.[15] Similarly, in 1885 the Warden of the British Columbia Penitentiary squabbled with local druggists over how a piece of patronage, the supply of drugs to the institution, would be distributed.[16]

While improvements in administrative efficiency were made with the lessening of patronage by the turn of the century, it probably did little to change the daily life of the inmate. It remained one of servile obedience and hard work. The rule of silence also continued to prevail. The 1899 Penitentiary Rules and Regulations laid down numerous punishments for fractious convicts. These

disciplinary actions included a bread and water diet, corporal punishment, shackling to the cell gate, hosing, and solitary confinement.[17] However, the exercise of this code of discipline was not always effected because of poorly trained staff and a lax warden. It was the opinion of Inspector Moylan in 1894 that the emeute at the St. Vincent de Paul Penitentiary in 1886, in which a convict was shot to death, was due to the neglect of penitentiary authorities in enforcing the rules and regulations.[18] In another case, it was clear to the Commission of Inquiry examining the Kingston Penitentiary in the late 1890s that many of its problems were due to the lack of harmony among the quarrelsome staff; consequently "a very low state of discipline" existed there, which contributed to escapes by prisoners and to the concealment of weapons by them. As well the penitentiary staff had not been observing the rules and regulations laid down.[19] Despite such problems in the management of Canadian penitentiaries the Auburn system of prison discipline nonetheless remained largely intact throughout this era. Indeed, another Government inquiry into Canadian penitentiaries reported in 1914 that "solitary imprisonment, labour and religious instructions have been the only agencies employed for the reclamation of the unfortunates." And of all the prisons on the continent, in probably none of them except the Kingston Penitentiary did the convicts spend so much time alone in their cells.[20]

One important change, though, for convicts was the introduction in 1868 of a system of remission. They could have up to five days a month remitted from their sentences for good conduct. This was done in order "to encourage convicts to good behaviour, diligence and industry, and to regard them for the same." At the same time provision was made for discouraging convicts from feigning illness in order to both escape work and at the same time shorten their sentence. Well-behaved ill convicts who were unable to work and were not malingerers were only entitled to half the monthly amount of remission.[21] In 1906 the law was

changed so that the amount of remission granted to ill convicts was at the discretion of the warden and the Minister of Justice.[22]

Those criminals who were particularly troublesome to penitentiary authorities were specially categorized as incorrigible prisoners, part of a labelling of criminals by late nineteenth century penologists which served to provide better explanations for crime and the criminal personality.[23] An answer to the problems posed by these prisoners was seen in a rigorous period of solitary confinement. To this end the Prison of Isolation was opened at the Kingston Penitentiary in 1894. It housed recidivists, those convicted of unnatural offences (i.e. sex offenders), and those convicts who had a "pernicious influence" on other convicts. These convicts were confined in larger cells than the general population, measuring some thirteen feet long, nine feet wide, and ten feet high, where they were both to live and to work. Apart for a short period of daily exercise they were obliged to labour at light work, in strict silence and on a reduced diet. While this facility for solitary confinement was never fully used between then and 1921 when it was permanently closed, it was clearly believed by Inspector Moylan, its chief promoter, that "the breaking of a man's corrupted spirit in the aid of reformation was a desirable and legitimate purpose of imprisonment." In this predecessor to the present day Special Handing Unit it was particularly clear that the prisoner, bereft of the rights of the ordinary citizen, was, as Moylan had stated in his annual report for 1879, "surrendered body and soul to be experimented upon."[24]

The behaviourist views of Inspector Moylan were typical ones for the late nineteenth and early twentieth centuries. The corrupted individual, the victim of a poor upbringing and ineffective socialization to the values of society, was to be removed to a purer environment in the form of the penitentiary. And this institution attempted to be an extreme imitation of the society outside its high and gaunt walls, turning bad habits into good ones.[25] Discipline was therefore

important, but prison labour also played a major role which was fundamental to the smooth administration of Canadian penitentiaries.

Prison labour was not only viewed as being morally useful to the convict and training for his release, but was also regarded as beneficial to the prison economy, contributing to the financial solvency of these institutions. Constant work would rehabilitate the convict, correcting the bad habits he had acquired in his youth and teaching him order, routine, and self-denial. Yet by the 1880s the key underpinning of the Auburn system of prison discipline had begun to disintegrate in a slow but sure fashion. With the industrialization of both Canada and the United States continuing apace in the 1870s and 1880s the burgeoning trade union movement successfully lobbied politicians against the use of cheaper prison labour by contractors, who had hired the convicts at a daily rate and supplied the equipment and raw materials necessary for the manufacture of such goods as shoes and cabinets. The contract system had already been weakened by the great economic depression of the 1870s, which had seen the boom years of the early 1870s end with the crash on New York's Wall Street in September 1873. Consequently at the Kingston Penitentiary, the only Canadian penitentiary where contract labour was in place, this practice was phased out starting in 1883. By 1886 all the contracts had expired and thereafter all the work done there was in the hands of the prison authorities.26

While it had always been difficult to keep prisoners fully employed at their assigned tasks, the passing of the contract system brought increasing amounts of idleness among convicts and the expenditure of great amounts of unproductive labour, such as on stone-breaking. In Canada after 1986 and in some American states part of the slack was taken up by making products for governmental use. However, the hopeful solution of the "public accounts" system did not go very far in tackling the problem since not enough work, particularly on a long-term basis, could be obtained to keep all the convicts busy enough. Another only partially

effective solution was to employ the convicts in penitentiary construction work, even though they were not terribly efficient labourers. Moreover, there was only so much of this work which could be done.[27] It was also dangerous. Some convicts lost their lives or were badly injured in construction accidents; indeed, the first penitentiary officer in Canada to die in the line of duty was Mason Instructor D. Cunningham at the Kingston Penitentiary in 1891. During the erection of the Prison of Isolation a convict working on a scaffold above him lost control of a wheelbarrow and it fatally struck the officer on the head. Death ensued within a matter of hours.[28]

Another attempt at providing work for convicts was made at the Kingston Penitentiary in 1894 when a binder twine industry was introduced. Although it was not in competition with domestic manufacturers, it nonetheless came under heavy criticism in Parliament in the late 1890s. The Conservatives, who were now the Opposition party, argued that free and honest workers were being put out of work. It was also claimed that future investment in Canada would be damaged if the state was involved in business activities. As a result the enterprise was discontinued in 1901 after its annual appropriation was voted down by Parliament. By 1896 the fear of competition with outside interests dominated all considerations over prison labour, with the consequence that by 1900 non-institutional labour was almost non-existent. The majority of prisoners now worked on farms attached to the various institutions, which, though seasonal in nature, did not face any pressure from political lobbies. However, in 1909 the Inspector of Penitentiaries stated that there was a "crisis" in prison labour. Institutional expansion had slowed down and only so much surplus labour could be absorbed in the penitentiary farms and quarries. As well the kind of work available was not particularly suited to the rehabilitation of the prisoners; even though many trades were represented in the penitentiaries there was in fact

a limited range of employment as the majority of labour used went towards the maintenance, upkeep, and expansion of the institutions themselves.[29]

In 1914 the problems caused by the lack of work for convicts caught the public eye because of the report of a Royal Commission into the state of affairs at the Kingston Penitentiary and into the penitentiary system generally. The investigation was instigated by Dr. W.S. Edwards, the Member of Parliament for Kingston. In December of 1912 he had written to the Minister of Justice, and laid charges against two officers at the Kingston Penitentiary. In his opinion, Deputy Warden O'Leary and the Surgeon Dr. Phelan were guilty of serious breaches of misconduct, including the gross neglect of duty, political partisanship and graft.[30] Although Edwards' charges were subsequently rejected by the three Commissioners in charge of the investigation, the report of the Royal Commission was the product of a thorough and exhaustive inquiry into affairs at the penitentiary. Its findings showed the prison administration to be patronage-ridden; that some of the punishments were degrading and inhumane; that the means of feeding convicts was wasteful; and that the attempts at convict reformation were half-hearted. Also criticized severely was the stone pile at the institution. There more than seventy convicts broke and piled stone while the air in the stone shed was full of stone dust, apparently because no adequate means was provided to remove it. Besides being degrading and unhealthy for the convicts, there was no profit in it for the penitentiary. It was simply regarded as the only way to keep convicts employed.[31] But perhaps the most scathing comment of the report was directed at the philosophy behind the punitive regimen of Canadian penitentiaries.

> They are old time prisons dominated by the idea that, not only should the offender be punished by being deprived of his liberty and confined by iron bars and stone walls, but that the avenging hand of the law he has violated should continue to bear heavily upon him in his place of incarceration. This policy is defended on the ground that the treatment of the prisoner should be so

> ordered as to be a constant deterrent against relapsing into crime, when he regains his liberty. It is a policy founded on revenge, mistrust, and fear.[32]

Upon the publication in 1914 of the report of the Royal Commission, newspapers across the country were quick to editorialize about the repressive nature of Canadian penitentiaries. Both Conservative and Liberal newspapers joined together to call for penal reform. One newspaper described the penitentiary system as "admittedly archaic," while another referred to these insititutions as "deary criminal universities" providing a better education in crime than could be had in the outside world. They made it clear to their readers that in truth the only purpose of the penitentiary was to break the spirit of the convict, not his reformation. The heaviest scorn of all was reserved for conditions at the Kingston Penitentiary. In 1915 these remained unchanged, with its stone pile still in operation. The Kingston Whig-Standard called it "that infamous place of refined torture where men are not only breaking stone but breaking their hearts as well-a place where the finest intellects are stunted and finally deadened." Similarly, the Toronto Globe considered it the duty of every citizen to see that the "disgraceful conditions" revealed by the Royal Commission were remedied.[33]

Despite such strong criticism penitentiary officials were unmoved by the report of the Royal Commission. In March 1915 the Inspector of Penitentiaries responded to the report, in a memorandum to the Deputy Minister of Justice, by considering it a naive effort. Stewart viewed many of the twenty-three recommendations made in it as "reactionary" in nature. These suggestions touched on a wide range of topics, including the use of parole, classification, prison labour, the education of prisoners, and on the introduction of indeterminate sentences. One recommendation urged the abolition of the hosing of convicts, the confinement of them in a dark cell, and the shackling of them with ball and chain. The Commissioners had found these punishments particularly reproachful. Douglas Stewart, however, regarded this view as simple minded for the

Commissioners had no experience in dealing with convicts. And all of the wardens, who were polled on these recommendations, were just as opposed as Inspector Stewart to any change in the rigid code of discipline at Canadian penitentiaries.[34] Similarly, in the House of Commons a year later the Minister of Justice staunchly defended the penitentiary surgeon--who had been censured strongly by the Commissioners--against attacks by W.S. Edwards. The Commissioners had found that there was much to be desired in his management of the insane ward, the prison hospital, and in regards to medical matters generally.[35]

Although changes in penal practice were definitely in the making by 1914, as evidenced by the reform-oriented report of the Royal Commission, Canadian penitentiary officials nevertheless generally stuck to the same views and assumptions in 1914 as in the pre-Confederation period.[36] The role of the penitentiary was still one of punishment, with rehabilitation to be achieved through the punitive mechanisms of imposing, fortress-like institutions. Attention had not yet turned to the convict as an individual, with a new emphasis on classification, education, and vocational training as the means to his rehabilitation. Real changes in Canadian penitentiaries lay two decades ahead, to be catalyzed by overcrowding and repressive conditions which caused prisoners to revolt and draw public attention to their complaints. But in 1914 Canada was still an "old pleasant, half-somnolent world, in which most Canadian communities had borne a striking likeness to Stephen Leacock's sunshiny little town of Mariposa."[37] The country had only just enthusiastically entered into an Imperial war which would prove to be a very tragic time in Canadian history, lasting for four long years at a terrible cost in manpower, money, and national unity. The war would mark the passing of the historical age of the nineteenth century, to be followed by a period which witnessed vigorous radicalism and social reform.[38] And eventually the closed world of the penitentiary system would catch up, albeit very reluctantly, to these new trends.

Medical Services

Like the purpose and regimented daily routine of Canadian penitentiaries in the period between 1867 and 1914, the provision of medical services appears to have changed little during this time. It still remained a subordinate priority to the discipline of these institutions. The surgeon continued to be responsible for examining the health of incoming prisoners, for the prevention and control of epidemics in the institution, and for the daily sick parade of convicts. He also advised on the fitness of convicts for corporal punishment, and on the prison dietary. The health care of the staff, too, was his responsibility.[39] All in all, the role of the physician did not change significantly from that of the pre-Confederation period.

Some of the penitentiary physicians spent a decade or more at this job. Like for Dr. Sampson at the pre-Confederation Kingston Penitentiary, this work was a major part of their careers. At the Dorchester Penitentiary its doctor laboured there for twenty-one years, from its opening in 1880 until his retirement in 1901.[40] Similarly, at the British Columbia Penitentiary its second doctor served from 1888 until 1920.[41] Yet the record for length of service must go to Dr. R.S. Black, who was first the physician to the Provincial Bridewell in Halifax and then remained in this capacity when the gaol became the Halifax Penitentiary after Confederation. From 1844 until 1880 he faithfully ministered to the needs of prisoners. Upon his retirement in 1880 Inspector Moylan paid him a warm tribute, reflective of the nineteenth century view of the physician as a gentleman. It also portrayed the prison doctor as being both a healer and a disciplinarian who had no difficulty at all in serving both functions.

> The surgeon, Dr. Black, who has been attending this Penitentiary for the last thirty-six years, has been most punctual and unremitting in his attention to those who required his professional aid. Few understood better the protean character, the whims and peculiarities of our convicts in their innumerable devices to

> impose upon the doctor, or could more successfully deal with the impostors, without exciting their ill will or wrath, than this veteran physician. Few, too, of the officers or convicts who have passed through the institution down by the sea since 1844, have left it without a pleasing recollection of and a friendly feeling towards the amiable and kind-hearted gentleman who, while attending to their bodily ailments, did not fail to administer, by way of advice and consolation, the healing anodyne to their aching and wounded hearts. My official and personal relations with Dr. Black have always been of the most agreeable nature and I regret they are at an end.[42]

While the long public service of Dr. Black was of great benefit to the penitentiary authorities, it was clear in one case that the retirement of the physician was overdue. In that particular instance the Commission of Inquiry investigating affairs at the Kingston Penitentiary in 1896-97 successfully repeated an earlier recommendation of the Inspector of Penitentiaries that this officer be retired. The increasing age and infirmity of Dr. Strange, then about seventy years old, had caused convicts to lose faith in his ability to properly and effectively carry out his duties.[43]

Until 1895 these physicians attended at each penitentiary on a part-time basis.[44] Some, though, had more onerous duties than others, because of the great variance in the population of the institutions. This fact was reflected in the range of salaries paid to physicians, an expense which was often closely scrutinized in Parliament.[45] In 1899, for example, the physician at the Dorchester Penitentiary received $1,400 for attending to its 226 convicts. By comparison, his counterpart at the British Columbia Penitentiary made $1,000 that year for attending--without also having a private practice--to its ninety convicts. At the St. Vincent de Paul Penitentiary its physician made $1,600 annually, while the physician at the Kingston Penitentiary made $1,800 annually. These two institutions had 447 and 570 convicts respectively in 1899.[46]

Pentientiary officials saw significant advantages in the employment of a full-time physician, despite the higher cost. In 1895 provision was made for

this practice by amending the Penitentiary Act. It was the experience of these officials in both Canada and other countries that physicians with an outside practice put this work ahead of their penitentiary duties. Consequently the medical officer was not always available in cases of emergency at a penitentiary, with sometimes half a day passing before he appeared.[47] In one documented case, at the British Columbia Penitentiary in 1892, the surgeon was reminded by the visiting Inspector of Penitentiaries that he should daily visit the prison and at a regular time, instead of three times a week at irregular hours. Furthermore, the physician had appropriated for his private practice medical equipment belonging to the institution and had been lax in vaccinating convicts against a threatened smallpox epidemic.[48] The amendment passed and the surgeon could no longer exercise his calling outside the penitentiary.[49] It had thus been clearly pointed out that the penitentiary surgeon's first duty was to the care of prisoners, a responsibility important enough to be ensured by the added expense of a full-time physician.

While the role of the physician generally remained static during the period between 1867 and 1914, the role of the hospital keeper or overseer did change somewhat from the pre-Confederation period. In 1870 a new set of Penitentiary Rules and Regulations required him to act as a druggist, charged with the responsibility "to make up all the presciptions, compound all the medicines, and see that they are administered in the form, and at the times ordered by the Surgeon." Also it was now his duty, not the surgeon's, to keep record books detailing how complaining and sick convicts were treated. These comprised hospital and dispensary registers, a case book, a register of deaths, and a hospital journal listing the prescriptions given. In addition, he had to keep a "Conduct and Industry Book." This record detailed the conduct of all hospitalized convicts, and the "Conduct and Industry" of all convicts employed in the hospital area and under the charge of the hospital keeper.[50] Besides perhaps

aiding in the determination of remission for ill convicts, the purpose of this record may also have been to ensure that discipline was properly maintained in the prison hospital, like in 1852 when the hospital keeper at the Kingston Penitentiary was instructed to compel hospitalized convicts to obey the rule of silence. The discipline of the penitentiary clearly had to extend throughout it if the punitive function of the institution was to be accomplished.

A common problem for many penitentiary physicians and hospital keepers in this era, like for their predecessors at the Kingston Penitentiary, was the lack of proper hospital facilities. The construction of the penitentiary system across Canada in the decades following Confederation was fraught with difficulties. Until 1895 the responsiblity for this major task was exclusively in the hands of the Department of Public Works. Besides being a slow process, this work was also sometimes marred by incompetence.[51] Some items took precedence over others, notably the erection of boundary walls, cell blocks, and workshops. Of low priority were the chapel, school room and hospital. As a result prison hospitals were generally temporary in nature for years or decades, causing wardens and surgeons to complain repeatedly about the inadequacy of these facilites or their lack of altogether. To add weight to their remarks they often cited the danger of an epidemic suddenly appearing in their midst and overtaxing the very limited hospital quarters.[52]

The hospital at the Kingston Penitentiary was praised often during this period, standing out as the model to be followed at the other institutions.[53] During these years it was modified but little, with changes only being made in its ventilation and its sanitary facilities.[54] In contrast, the situation elsewhere left much to be desired. At the St. John Penitentiary, the fact that it also served as city jail meant the admission of many short-term prisoners who were in a debilitated state, especially from alcoholism. Scarcely fit for the hard labour of the penitentiary, nearly all of them had to be confined to the

prison hospital. Yet until 1876 the only space available for this facility was an area at the top of the male cell block. It was regarded as a dangerous situtation because healthy prisoners elsewhere in the prison could not avoid breathing the "vitiated" air from it, which was thought to carry disease. In 1876 this state of affairs was finally rectified with the provision of a large ward.[55] It was different situation at the Halifax Penitentiary, which seems to have had an adequate hospital. Apparently it was little used, for the space was appropriated in 1875 for the storage of the products of the broom corn workshop at the prison.[56]

In 1880 these two Maritime prisons were replaced by the Dorchester Penitentiary. Most of its early structures were wooden frame buildings, and this description applied to the prison hospital. It was located in a building once used as a laundry. At first it only comprised a large ward, which caused security problems and required extra guards. In the late 1890s it underwent renovation to enlarge it and remedy its defective heating. Finally, a new facility replaced it in 1923 because despite efforts to make it as clean, comfortable, and as sanitary as possible, it was still an "eyesore" in the institution.[57]

A similar period of time elapsed before a permanent hospital was built at the St. Vincent de Paul Penitentiary. Its first hospital was an open ward located on the second floor of the main building, with an additional ward available on the floor above in case of an epidemic at the prison. From the start it was viewed as inadequate, being noisy, poorly ventilated, and too small. Antiquated and often complained of, its replacement was long in coming. While a contagious ward was opened in 1900, construction of the new hospital only started in 1908. Even then it was much delayed and a new hospital did not open until 1926 or 1927.[58]

In Western Canada it was much the same story. At the Manitoba penitentiary, opened in 1877, the opening of its permanent hospital was delayed for a decade. In the interim ill convicts were kept in their cramped cells until 1884, when a temporary infirmary was opened in a building intended for "refractory convicts." This facility was later relocated to the attic of the main building of the penitentiary. Work on a permanent hospital was started in 1887 and completed in 1888. The penitentiary surgeon was happy that the new facility was finished because on several occasions the temporary infirmary had proved to be too small for the needs of the institution. In addition, the design of the permanent hospital, modelled after the one at the Kingston Penitentiary, made possible the total separation of the convicts from the so-called "dangerous insane" of the North-West Territories who were lodged at the penitentiary in the 1880s and early 1890s. This "commodious, lightsome, well-ventilated" building was expected to serve well the needs of the institution for the next fifty years.[59]

The worst frustrations, however, at delays in hospital construction were experienced at the British Columbia Penitentiary. It was the smallest penitentiary in the country. Until 1891 it did not have any hospital quarters, leaving sick convicts to be confined to their cells. This "pernicious" situation was particularly hard on Indian prisoners, nearly all of whom were scrofulous. The temporary solution adopted was to convert the Deputy Warden's quarters into a hospital ward. Nevertheless this was still an inadequate situation, as the Surgeon called a number of times for the erection of a suitable hospital. However, the Inspector of Penitentiaries regarded this accomodation as satisfactory for extra room at the prison could be made available if required. Not until the early 1920s would a permanent facility be in place.[60]

Another difficulty faced by penitentiary physicians in this era was sanitation. Polluted water supplies and poor sewage treatment were major concerns for some Canadian penitentiaries. Problems first appeared at the

St. John Penitentiary. In 1870 two abbatoirs were built near it, and the offal from them flowed down-stream to pollute the reservoir from which the prison drew its water supply. The result was a putrid and odorous water supply. The Government launched a civil suit versus this nuisance, but it went against the Penitentiary, with the judge ruling that it was not within the reference of the court because of a flaw in the indictment. The ensuing appeal to the local Board of Health, by the Board of Directors of the penitentiary system, resulted in the passing of bylaws to ensure that the abbatoirs were operated in a sanitary manner. However, the local Health Officer did not enforce these bylaws. A final solution to this problem apparently only came in 1874 when a well dug in the prison yard provided a more than adequate supply of water.[61]

In 1899 it was reported that the sewerage at the Dorchester Penitentiary was defective and unsanitary, which was the result of poor planning. Instead of the existing vitrified drain pipes, all cast iron pipes were installed as well as adding new sewers and manholes. A new sewage works was also constructed. In 1900 the penitentiary Surgeon reported that the sewerage system was continuing to work well.[62] A different kind of problem existed at the St. Vincent de Paul Penitentiary. There three-quarters of the sewage was used on the institution's farm, with the rest discharged into a small stream outside the prison. In 1899 a neighbouring land owner sued the Government for damages, charging that the polluted stream had damaged his property. Other local inhabitants also complained of the practice. Accordingly, a new system of sewer pipes and ducts was laid, and it appears to have been fully operational by the fall of 1903.[63]

Sewage disposal was likewise a serious problem at the Kingston Penitentiary in the 1890s. It had long been a perplexing problem for the prison authorities, and it was now drawing complaints from local residents. The latter repeatedly pressed upon the Government that the penitentiary sewage, discharged into

Lake Ontario less than a mile from the city, was polluting their own water supply. In 1895 a magazine article reported that a new and modern sewage treatment system was now in place, with a cesspool from which the chemically purified sewage was sent to the penitentary farm for use as fertilizer. Yet the Commission of Inquiry which investigated the state of affairs at the institution in 1896-97 found this system defective and recommended its replacement. Evidently this call was heeded, for in 1900 the prison surgeon stated that the sewage system, "far ahead of anything of the kind in any public institution in Canada," was being operated "in a most satisfactory manner."[64]

At the Manitoba Penitentiary concern was expressed in 1897 and again in 1901 about the overflow of liquid sewage onto the flat land outside the prison. It was feared that in a hot dry season this might lead to an epidemic. Steps to overcome this problem were undertaken in 1902 and were completed in 1903.[65] Similar difficulties had been experienced a decade earlier at the British Columbia Penitentiary. In 1888 it was discovered there that defective drainage had caused foecal matter to accumulate under the rotten wooden floor of the prison basement, a state of affairs which the Inspector of Penitentiaries described as "shocking." The situation was soon remedied by the laying of a new cement floor. The prison water supply was a matter of concern in the early 1890s because it was polluted by nearly lumbering. This problem was solved in 1893 when the penitentiary was connected to the water supply system of the nearby town of New Westminister.[66] The existence of such problems demonstrates that these fortress-like institutions were hardly well-designed and constructed buildings.

In contrast to whatever sanitary problems they may have had to face, penitentiary physicians and hospital overseers were fortunate in the period between Confederation and the First World War because their institutions were rarely visted by fatal epidemics. Occasionally the threat of smallpox loomed, but apparently this scourge did not get past the gates of Canadian

penitentiaries, except for one non-fatal case at the Kingston Penitentiary in 1907 or 1908. On that occasion the spread of this "loathsome" disease was prevented by confining the convict to an isolated building within the penitentiary walls.[67] The institution was also seriously endangered in the fall of 1908, when the disease was present in epidemic proportions in the nearby village of Portsmouth.[68] There had been similar cause for alarm on many other occasions. For example, in 1886 the feared scourge was present in the neighbourhood around the St. Vincent de Paul Penitentiary. This was during the Montreal epidemic which took 3,164 lives.[69] But in this case, as at other Canadian penitentiaries, the systematic vaccination of the convict population gave the penitentiary a solid measure of protection from the fearsome disease.[70]

Typhoid fever proved to be a more serious problem, though not to the degree to which it had struck at the Kingston Penitentiary in the 1860s. The worst mortality from it came in 1895 at the Dorchester Penitentiary, when five convicts fell victim.[71] Usually only a few deaths were recorded in any of these outbreaks; at the Kingston Penitentiary, for example, it struck fatally in 1886 and 1893, with one death in 1886 and two deaths in 1893.[72] In the 1890s this disease had lingered there between 1891 and 1897.[73] While Canadian penitentiaries in this period--like the society outside them--did not have to face serious epidemics, apart from smallpox which in a penal setting could be effectively vaccinated against, it was not the end of this grave danger. In 1918-19 a worldwide pandemic of influenza would take a heavy toll of lives everywhere it struck, including at Canadian penitentiaries.

In this era tuberculosis was a more significant cause of death among convicts than was typhoid fever, as had been the case at the pre-Confederation Kingston Penitentiary. Endemic to Canada in the nineteenth century, this disease regularly claimed victims at all the penitentiaries. For example, during the 1890s 37 of the 123 deaths reported by these institutions were attributed to this

cause.[74] In many cases it was a lingering death which stretched over months and, on occasion, even years. More would have died in prison but for the granting of remission to them so that they could die among friends shortly after their release.[75] These patients also taxed the financial resources of prison hospitals because of their long stays as "consumption," the seventeenth century term for the disease, inexorably made their bodies waste away.[76]

At the Manitoba Penitentiary the Surgeon faced a special problem in dealing with tuberculosis. The Native convicts it received were easily struck down by the disease and many required hospital treatment. Consequently its drug bill was higher than that of any other penitentiary. At the British Columbia Penitentiary, in contrast, its Native prisoners did not find prison life so exceedingly hard on their health. During the 1880s this matter of high drug costs was discussed several times in the House of Commons in the course of approving the annual budget of each penitentiary.[77] Moreover, these were expensive drugs, as the Surgeon of the Dorchester Penitentiary pointed out in 1899.[78] Interestingly enough, between 1897 and 1916 the cost of drugs was measured on a per capita basis for each institution, as any sign of waste and extravagance was to be closely guarded against. In this era the penitentiary was supposed to be a model of efficiency in all its departments, and it was obviously believed that the efficiency of medical care could be so easily and effectively measured.

Until Robert Koch's discovery in 1882 of the tubercle bacillus the etiology of tuberculosis was generally regarded as hereditary.[79] For much of this period the disease therefore only aroused occasional comment from Canadian penitentiary physicians, despite its virulence. And then these practitioners tended to talk about how the prison environment contributed to the disease. In 1868 John R. Dickson, the Surgeon at the Kingston Penitentiary, connected the unhealthiness of

the cold and damp prison flagging to the high number of scrofula cases under treatment. He also drew attention to the fact the Negro and Indian convicts could not remain long in the penitentiary before they were attacked by the disease. And this was especially the case for the latter. Only a tenth (four) of these cases of glandular tuberculosis were hospitalized, with the rest assigned by the Surgeon to light work.[80] Similarly, in 1884 J.T. Pominville, the Surgeon at the St. Vincent de Paul Penitentiary, noted how most of the deaths at the institution since its opening in 1873 were due to tuberculosis. In his view, "A retired and monotonous life, mental depression, and more than that, the humidity which must naturally exist in buildings comprised entirely of stone, explain why this disease makes so many victims in institutions of this kind." He reported that many of those who were pardoned on this account died a few weeks later, with friends or in hospitals.[81] Even as late as 1906 one penitentiary physician continued to view the disease as partly hereditary in character. Dr. Daniel Phelan, the Surgeon at the Kingston Penitentiary, believed that poor habits together with a poor constitution contributed to worsen a latent tendency to the disease.

> ...in the pulmonary variety we should be more impressed with the idea that it is not only infectious and communicable where simple sanitary requirements have been neglectd. The effects of confinement on systems hereditarily below the average and already weakened down by vice of all kinds, tned to hasten any disease latent in the system, and on this account an isolated case of one of the varieties of tubercular disease may be found cropping up. The laws of health cannot be infringed on with impunity, especially by those in whom there is a weak link in the ancestral chain.[82]

Although by 1900 tuberculosis was generally regarded as infectious it does not seem to have been seen as posing a particularly serious danger to the health of the convict. The disease had infected the convict before he entered the penitentiary, as Dr. Phelan argued in 1910, and "only required some favouring influence not develop it."[83] Nonetheless, in his annual report for 1899 he did

note that all precautions were taken against its spread within the institution.[84] Other diseases such as smallpox and diptheria were more feared, and it seems that the only time tubercular convicts were isolated from the general prison population was when their health required hospitalization.[85] Another decade was to pass before better detection methods would alert penitentiary officials to the danger of tuberculosis carriers, both among staff and convicts, within the walls of Canadian penitentiaries. In contrast, in the United States prison physicians became increasingly interested in the disease in the 1890s. While a few innovative developments took place there in the early 1890s, special provision for tubercular convicts would also generally be delayed for two or three decades.[86]

During this era, as was the case at the pre-Confederation Kingston Penitentiary, the treatment and care of insane convicts proved to be the major medical problem in Canadian penitentiaries. In 1856 the Board of Inspectors at the Kingston Penitentiary had gladly welcomed the opening of the Criminal Insane Asylum at the nearby 'Rockwood' estate.[87] Although all the insane convicts had been transferred from the penitentiary to the asylum by 1865, this arrangement did not prove to be a lasting solution to the serious problems posed by criminal lunatics in the penitentiary.

The main purpose of the Criminal Insane Asylum at Rockwood had been to house convicts who became insane while in the penitentiary, with space also reserved for those acquitted of crimes on account of their insanity, those found unfit to stand trial, and those regarded as the so-called "dangerous insane." This last and most numerous group could be committed to the asylum by Justices of the Peace, who would issue a warrant for the custody of any person deemed insane and regarded as "dangerous to be at large." Most of the admissions to the institution proved to be from this group as relatives of the insane and Justices of the Peace abused the practice. The root of this misuse was two-fold.

Firstly, desperate relatives wanted to ensure that these persons would be kept in proper custody, in a jail and then in the Asylum at Rockwood. Secondly, because Eastern Ontario lacked a general asylum many relatives sought to have the insane admitted to this institution because it would save costs as well as perhaps making visits with them easier than if they had to travel to Toronto. Local authorities, too, often colluded in this scheme as they also desired to reduce costs.[88]

In response to this problem it was urged as early as 1862 that the Rockwood Asylum be converted into a general asylum for the eastern area of the Province.[89] A solution was definitely needed for the provincial Government, responsible for the maintenance of the "dangerous insane," was in effect, after Confederation, largely paying for an institution under Dominion control. By 1870 negotiations to this end were underway, punctuated by the frequent calls of the medical Superintendent for the removal of insane convicts from the Asylum because they were a disruptive influence on the other patients.[90] In 1877 arrangements were completed and the asylum sold to the Province of Ontario. Its twenty-one convict lunatics were sent back to the Kingston Penitentiary. During the 1870s this class of patient had made up a scant 3% of the admissions to the asylum.[91]

Upon their arrival at the Penitentiary the insane convicts were lodged in the lower ward of the hospital. Plans for a new prison asylum had been drawn up in 1876 and construction of it was underway a year later. It had formerly been the West Workshop of the institution. The new facility would, as the Warden of the Kingston Penitentiary predicted, "be found more convenient, and quite as good in every respect as could be procured in any Asylum in the Province."[92] The renovation of the building proceeded slowly, because most of the convict stone-cutters were occupied in preparing stone for the nearby Royal Military College. This caused some unease on the part of Inspector Moylan, for if a contagion broke out at the prison room other than in the hospital would have to be found for the insane convicts.[93] Such fears proved unwarranted and the

hospital "afforded sufficient accomodation for the number of insane who required constant surveillance."[94] In 1881 the new asylum was finished, and the prison Warden described it as "admirably adapted" for the intended purpose. This massive stone and ironwork structure was three stories high, with cells for twenty-eight lunatics. A workshop took up half of each of the first two floors, while an open ward was provided on the third floor, for the use of patients during the day. In addition, the asylum was heated by hot water, an innovation at the institution.[95]

In charge of the new facility was Dr. M. Lavell, the penitentiary surgeon. In his annual report for 1881 he stated that this duty was not an undue burden for him. He considered the lunatics well-behaved, and rarely sick enough to require medical treatment. Since only those convicts unfit for work were received there, his first priority was to return them to work. And, importantly, at the same time he tried to prevent the prison asylum from being filled up with "weak-minded men and imbeciles," who, if allowed, would prefer to escape the hard labour of the institution, the "proper punishment for their crimes."[96] The ideal of work as serving the purpose of punishment, reform, and deterrence of criminal behaviour thus clearly extended to the prison asylum.

Dr. Lavell was not alone among Canadian penitentiary officials in his concern about "weak-minded men and imbeciles." In 1886 the Surgeon of the Dorchester Penitentiary drew attention in his annual report to the small number of convicts received there whom he could not better describe than as "inoffensive fools." These persons, being a nuisance in their local communities, were given long sentences for crimes which otherwise would not be so strictly punished. In order to better care for some of these convicts part of the prison hospital was partitioned off for their use.[97] As a solution to this problem both the Dorchester Surgeon and the Inspector of Penitentiaries called in 1886 for a certificate of the mental health of the prisoner, in addition to the existing

practice of having the sheriff or other officers bringing the convict to the penitentiary provide proof that he was free of any "putrid, infectious or cutaneous disease."[98] Concern was also expressd in this era over the fact some insane convicts should have been found so at their trial, and sent to a provincial insane asylum instead of to a penitentiary. That this was not done was seen by penitentiary authorities as an imposition upon them.[99] In his annual report for 1882 Inspector Moylan summed up the serious problem posed by the mentally ill and the mentally retarded convicts in the penitentiary system.

> It is the experience of the Wardens, the Surgeons and the other officers who have to deal with such prisoners that, for the most part, they are irresponsible, not capable of discriminating right from wrong, and that they should have been sent rather to an insane asylum than to a Penitentiary. Their presence in a penitentiary impairs discipline. They are in constant violation of the rules, for which it were a cruelty to punish them; yet their example is very often taken advantage of by the ill-disposed, who will raise the cry of favoritism and injustice, if they meet with their deserts.[100]

The prison asylum at the Kingston Penitentiary also took in insane convicts from the other penitentiaries. These were only a few or so in number each year.[101] None, though, could be sent from the British Columbia Penitentiary until the completion of the Canadian Pacific Railroad in 1887. Four convict lunatics were then sent to the asylum, whose transfer was a great relief for the officials at the British Columbia Penitentiary since two of them were very violent and noisy.[102]

Despite all the work expended in providing a special building for the insane ward at the Kingston Penitentiary, it soon proved to fall short of its promise. By 1886 the Inspector of Penitentiaries was calling for its replacement, a recommendation which he would repeat every year until his retirement in 1895. In the opinion of Inspector Moylan it was not suited for its purpose. The noise and vibration of the flour mill within the building greatly disturbed the patients,

who also had to suffer all year round from being confined within doors and deprived of the air and exercise seen as necessary to their recovery.[103] Only after much of prodding from the Inspector was an exercise yard made available for the patients in 1887.[104] The harshest plea for a new asylum came from J.H. Tuke, a prominent English alienist who had toured American and Canadian insane asylums in the early 1880s. He found the patients there treated almost as strictly as convicts, confined in prison cells with stone floors and subject to punishment in dungeon-like basement cells. In his view the distinction between convicts and lunatics could not be blurred, as was the case here: "for criminals of the worst class this building is admirably suited, but it is astonishing that it should have been constructed for lunatics in recent times."[105]

In 1891 the Minister of Justice, Sir John S.D. Thompson, acknowledged in the House of Commons the need for a new asylum at the Kingston Penitentiary. He cited the lack of space needed for the proper exercise of the convicts then there.[106] A year later Thompson succeeded in having an appropriation of funds voted by Parliament for the construction of a new asylum, a move spurred on by the annual report for 1891 of the Inspector of Penitentiaries.[107] On this occasion Moylan had again decried the conditions in the insane ward.

> The strictures which have been passed upon the present makeshift asylum by medical men, especially by experts, have been many and severe. The fact cannot be disguised that our criminal lunatics do not and cannot, under existing circumstances, receive the treatment which their helpless and miserable condition calls for, and which should be somewhat in accord with the benevolent spirit and laudable progress of the times. I recommend, with all the force and emphasis I can give the recommendation, that an insane asylum, in the true sense of the term, be built as soon as possible to provide the means and commence the work.[108]

Consequently a site was chosen for the new asylum and plans for it were drawn up. The first step in its construction was the erection of a new wall to enclose it at the east side of the penitentiary. This work was started in 1893 but after that nothing further was done.[109] Other construction projects at the

institution evidently had more priority, despite the great suprlus of convict labour during the 1890s. Another cause of the inaction here may have been the inefficiency of the Clerk of Works at the Kingston Penitentiary, who in practice assumed the role of architect for the prison. In his annual report for 1894 Inspector Moylan complained of the incompetence of this officer and how it greatly impeded the addition of necessary facilities for the prison.[110] But such a situation was not typical of the institution at that time, as the Commission of Inquiry which investigated the state of affairs there in 1896-97 had found it poorly managed.[111] The report of this Commission also strongly critized the provision for the insane at the penitentiary, echoing the long-standing complaints of Inspector Moylan.[112]

The criticisms about the penitentiary asylum did little, if anything at all, to ameliorate the life of the insane there. The depressing asylum conditions continued to persist for want of a better solution. In 1903 the Warden of the Kingston Penitentiary squarely addressed this problem, stating in his annual report that

> The important question as to the proper disposition of insane criminals is still with us and, so far as I can discover, is as far from solution as it was twenty years ago. The Penitentiary Act provides for the removal of an insane convict to an asylum during the period of his insanity and for his return to prison if he recovers before the expiration of his sentence. Practically the clause is a dead letter. Insane convicts remain with us, subject to such treatment as can be given within closed walls and prison cells during the whole term of confinement and, often for weeks and months longer. If there be anything in the modern theories as to the proper treatment of the insane, our present system of prison asylums is indeed difficult of defence. I admit the apparently insurmountable difficulties in the way of the satisfactory solution of the question, but the existence of those difficulties need not paralyse the sympathy and philanthropy of those public or forbid the active consideration of the problem. We have forty insane convicts in a single building, favoured with the daily visits of the surgeon and left to the managment of prison guards. How many of these should have been sent to prison at all? How many should remain in Prison? What shall be done with those who do remain?[113]

Some improvement, however, of this situation came in 1907 when the provinces of British Columbia and Manitoba started accepting insane convicts into their asylums. No federal-provincial agreements were signed at the time regarding this arrangement.[114] It was the first use of legislation passed in 1895 for this purpose.[115] It had been enacted at that earlier date in response to federal-provincial negotiations for the provinces to take over the care of insane convicts.[116] But this change in practice had little effect on the operation of the insane ward at Kingston. Its fluctuating population rose from twenty-seven in 1908 to a high of fifty-three upon its closure in 1915.[117]

The long story of neglect and grossly inadequate conditions in the criminal insane ward at the Kingston Penitentiary could not continue forever. The breaking point came in 1914 with the release of the findings of the Royal Commission which had been investigating the Kingston Penitentiary and the penitentiary system generally. The report paid particular attention to the Department of the Insane at the prison. This Department was primarily serving a custodial function, with only a cursory amount of medical care given there. It was clear to the Commissioners that proper care and attention had not been provided for the forty-odd patients there. Instead of the level of care their mental state demanded, what actual care they received left much to be desired.[118] Dr. E.H. Young, the Assistant Superintendent of the nearby Rockwood Hospital for the Insane, provided the Commissioners with an expert opinion on the condition of the insane ward at the penitentiary. His comments echoed previous opinions on the subject.

> The building in which the insane are at present housed is, in my opinion, entirely unsuited to the purpose for which it is used. It is defective in structural arrangement, lacking in nursing and medical facilities and devoid of means of providing occupation. The physical condition of the patients shows the effect of improper diet, insufficient exercise and fresh air. Each patient is locked in his cell, without proper sanitary convienences from 4 p.m. to 7 a.m.; the door of each cell is simply a grating, and there is no

> provision for the isolation and care of noisy and filthy patients. There is no provision for the proper classification of patients, all of whom are gathered together in a large day room, the acute with the chronic, the old and helpless with the impulsive and violent, the lucid with the demented.[119]

The Commissioners also found in their investigation that unruly patients were inhumanely punished by being forcibly subjected to cold water baths. This practice was known as "tubbing."[120] Yet the evidence is contradictory on this point, and both the Minister of Justice and the Inspector of Penitentiaries rebutted the charge. The latter stated in his annual report for 1914 that this was done for sanitary reasons only, when insane convicts refused to bathe periodically. It was not a punishment.[121] Whatever the truth of this particular matter, it is clear that the nature of the care of the insane at the Kingston Penitentiary was designed to incur as little trouble as possible for those in charge. The Commissioners succinctly concluded that, "It may be fairly said that the manner of dealing with the insane is a striking criticism, not only of the individuals concerned, but also of the system of administration which has permitted such abuses to go unchallenged all these years."[122] And in part the responsibility for these conditions fell on the penitentiary surgeon.[123]

The reaction of the Minister of Justice to the harsh criticisms about the insane ward at the Kingston Penitentiary was a stalwart defense of the actions of the penitentiary surgeon, Dr. Phelan. In March 1916 Charles Doherty stated in Parliament that prior to the work of the Royal Commission he had been aware of the need to improve the conditions there. He had therefore thought the matter should be dealt with as part of an inquiry into the general state of affairs at the Kingston Penitentiary, so that he would benefit from the Commissioner's advice. Doherty defended Dr. Phelan against the charge that he should have drawn to the attention of his superiors the conditions in the insane ward. The Inspector of Penitentiaries, together with Assistant Inspector W.S. Hughes, knew

well of the conditions there and were not dissatisfied with them. And, as the Commissioners had noted, Dr. Phelan had not created the system for the care and treatment of the insane convicts. He was only carrying on the existing practice which he found in place at the time of his appointment in 1897. Nor, as was alleged, did the surgeon devote insufficient attention to the insane prisoners, because he was acting in the joint capacity of superintendent of the insane ward and surgeon of the penitentiary. While Dr. Phelan had not in his annual reports given any sign at all of problems in this area, he was absolved of any wrongdoing because, although he might have lodged protests about this situation, he was a "very subordinate" employee and the responsibility for these conditions was held by his employers.[124]

Yet in fact the Minister of Justice had such a high esteem for Dr. Phelan that he tried to arrange in Janurary 1915 for the latter's appointment as Medical Superintendent of Canadian penitentiaries. The duties of this officer would be to examine penitentiary hospital conditions, with a view to their improvement; to examine methods of medical treatment and medical equipment and supplies; to make periodic inspections of penitentiaries; to supervise pentientiary surgeons; and to examine and report upon suspected cases of insanity among convicts, together with occasionally visiting the provincial mental hospitals to which insane convicts would be sent. The Minister of Justice believed that Dr. Phelan was especially well qualified for this proposed post, "in view of his long experience at Kingston and the fact that he has made a special study of insanity."[125] The latter reference appears to be to the surgeon's writings on the relationship of crime and insanity. These were published in the Proceedings of the Annual Congress of the American Prison Association.[126] On this occasion, too, he defended the penitentiary surgeon against the charges that the responsibility for the conditions in the insane ward at the Kingston Penitentiary fell in part upon him.[127] However, the federal Cabinet evidently rejected this proposal. The

appointment of a director of penitentiary medical services would not come to pass until 1947, more than three decades later.[128]

Although penitentiary officials rejected any claims of wrongdoing here by Dr. Phelan, action was nonetheless taken to remove the convicts from the insane ward at the Kingston Penitentiary and to close this facility. In July 1914 negotiations commenced with Ontario, Quebec, New Brunswick, and Nova Scotia for the reception of these forty seven convicts. Of this number twenty-four were from Ontario, thirteen from Quebec, and the remainder from the other provinces. After much correspondence between the Minister of Justice and the provincial governments of Ontario and Quebec negotiations were successfully concluded by February 1915.[129]

The Quebec Government had quickly agreed to the request of the federal Government to care for insane convicts from the province, providing for their admission into privately run mental hospitals so that in no way would these convicts be under Government management.[130] However, the Ontario Government was not so accomodating. The provincial authorities were told by the federal Government that the intended change in the care of these "unfortunate persons" was to be only a temporary measure, until the Dominion was able to establish a special institiution for all the criminally insane of the country.[131] Even so, the provincial authorities declined at first to be involved in the care and management of these convicts, citing in November that it was improper to have the criminal insane in a regular asylum as was then the case for its own such prisoners. Furthermore, its various asylums were then crowded to the maximum.[132] In February of 1915 the Minister of Justice again renewed his request, imploringly stating to his provincial counterpart "the very great importance" of finding a better method of treatment for these convicts.[133] Now the provincial government quickly changed its mind. It set aside for an insane ward part of the newly completed reformatory at Guelph, comprising a ward of three dormitories.

Violent patients requiring detention in individual rooms were to be sent to the asylum at Hamilton. It was a major improvement over the conditions at the insane ward in the Kingston Penitentiary, for now these patients would be under the charge of professional staff and employed, when able to be, at gardening and other appropriate outside work. Another important consideration for penitentiary officials was that the Province agreed to take care of all the insane prisoners at Kingston, regardless of the province they were domiciled in.[134]

With these arrangements complete, thirty-eight insane convicts were transferred to the Guelph reformatory in July of 1915. The rest were either deported or sent to mental hospitals in other provinces.[135] The much-criticized Dr. Phelan remained on staff at the Kingston Penitentiary until the end of the year. He was then retired on superannuation since with the closing of the insane ward his position was abolished. In his stead joint surgeons were appointed to the institution, with one attending there daily and the other serving as a consultant.[136] For the time being at least the difficulties in the care of insane convicts had been resolved satisfactorily.

The substandard care and treatment of insane convicts in the penitentiary system during this era points to the fact medical services had a low institutional priority. As in the case of insane convicts, the truth of this situation was made very clear by the report in 1914 of the Royal Commission investigating the management of the Kingston Penitentiary. The evidence taken during the investigation demonstrated that the convicts received scant medical care. The examination of convicts newly received into the prison was a perfunctory affair, with scarcely any records kept of it. Because the mental health of the convict was not being thoroughly examined at this time, imbecilic recidivists were being put in with the general penitentiary population. When they broke the prison rules and regulations they were punished, even though they were in fact not responsible for their actions. Also inadequate was the one or

two hours daily attendance by the penitentiary surgeon, a length of time which was hardly sufficient for the medical needs of the 500 prisoners.[137] Radical changes were also needed at the prison hospital, of which the Commissioners were severely critical.

> ...It is difficult to conceive what characteristics of the building set apart for the care of the sick at the Kingston Penitentiary warrant it being designated "hospital." There is nothing in the building or equipment which justifies the name. Some 36 inside cells, inferior in their arrangements to the cells occupied by the healthy prisoners, house those whose illness is serious enough to make necessary their admission. In these cells there is not effective ventilation, and save for an obsolete bucket for the excreta, sanitary appliances are absent. The two baths and water-closets are hopelessly out of date. Under no conditions are the patients permitted to have exercise in the fresh air, nor indeed to leave their cells for any purpose.
> ...The operating room (so-called), where serious cases have been, and must be dealt with as they arise, has an old wooden table but no other equipment. When your Commissioners visited this room, many old books lay about the floor and the place was not clean. In all, there was a condition of affairs which should not have been tolerated. Again, there is to be noted an all but complete absence of satisfactory records. Inspector Stewart's commendation of the existing conditions can only mean that he is not competent to express an opinion upon this aspect of prison management. Although his annual reports give a different impression, the surgeon in his evidence before the Commission stated that many changes were necessary to make the hospital what it should be.[138]

In light of these unfavourable judgements the Commissioners recommended a new hospital be provided, "modern in plan and equipment," together with a reorganized staff made up of a visiting surgeon, a resident physician, two trained male nurses, and convict orderlies. The part-time visiting surgeon would be in charge of the medical department, attending at the institution daily and visiting ill staff members at their homes. The part-time resident physician, preferably a recent graduate with training in psychiatry, would carry out physical examinations of all convicts and perform laboratory work. In addition, he would handle emergencies and minor illnesses. This setup would help avoid the stagnation that had beset the medical department there, since "a physician in

active service will be more likely to be abreast of modern methods and will be disposed to treat the prisoner inside and the patient outside with the same care and consideration." Furthermore, a part-time physician would not be prone to the "enervating effects of a purely institutional practice," which were well known.[139]

When the Inspector of Pentientiaries and his wardens were polled in early 1915 on these recommendations about penitentiary medical services, their reception of them was, at best, lukewarm. To have this large a staff was considered "rather too elaborate" for the needs of the various penitentiaries; at the small institutions where the average hospital population was two or three this measure was seen as "absurd." Generally one physician was considered enough. Moreover, at the two larger institutions, Kingston and St. Vincent de Paul, the average number hospitalized was only about ten, of whom few were seriously ill. Trained male nurses were not regarded as essential but did deserve preference in hiring; their use, as two wardens pointed out, was more in the nature of a temporary expedient.

The penitentiary officials approved of the Royal Commission recommendation that each prisoner, on his arrival, receive a thorough physical and mental examination. This would include, as far as possible, information on his past and his family history. It was thought by these men that this was an unobjectionable extension of an existing practice; however, they considered the personal information about the convict to be of "very doubtful practical value." As for the suggestion that a modern hospital be provided, four of the seven wardens agreed with it. Of the other three, one thought that any deficient penitentiary hospital should be modernized, another had no comment, and the third regarded the existing facilities as quite adequate. However, Inspector Stewart labelled this recommendation vague and naive. He saw nothing wrong with the Kingston Penitentiary hospital, a facility where security was the primary consideration.

He admitted some prison hospitals were inadequate, but only because they were intended for temporary use. Proper facilities would be provided in future building programs.[140] In contrast, when the two physicians who replaced Dr. Phelan at the Kingston Penitentiary took over in 1916 they found the prison hospital lacking in the construction or facilities of any modern hospital. Similarly, the operating room was totally lacking in the equipment needed for any serious operations. Plans were then underway to improve the lighting in the cells and to furnish it with the necessary instruments and supplies. The new surgeons also found the nursing staff at the hospital bereft of any knowledge of contemporary medical methods and techniques.[141]

While the Inspector of Penitentiaries and the wardens under him certainly did not share the view of the Royal Commission about the need to improve penitentiary medical services, this divergence of opinion nevertheless signals a turning point. For the first time, evidently, attention had been drawn publicly to the need for prisoners to receive health care on a par with that in the outside community. The penitentiary system was seen by outsiders as needing to march in time with the medical progress taking place outside its gaunt and austere walls. Yet penitentiary officals obviously continued to regard the provision of medical services as secondary to the discipline of the prison. A rigid standard of discipline was the rule as the heavy hand of retribution continued to weigh down on the convict. More emphasis on medical services would have to wait until the idea of rehabilitating the individual offender, instead of the mass of offenders, came into vogue in the 1930s. Then, in that context, the physical and mental health of the prisoner would achieve a new importance.

Introduction

The period between 1915 and the report of the Archambault Royal Commission in 1938 was a transitional period for the Canadian penitentiary system. It marked the twilight of the Auburn system of prison discipline, with its rigidly enforced code of discipline, and the eve of the arrival of a new correctional philosophy, the treatment ideology, with its focus on the offender as an individual. This passage was not an easy one, as the 1930s saw both riots and stormy public debate over the administration of the penitentiary system.

In the late 1910s and the 1920s Canadian penitentiaries were run in much the same fashion as in previous decades. Convicts continued to labour together and spend the remaining time alone in their cells. Some rules were relaxed, particularly the rule on silence, but the aim of the penitentiary system did not change substantially. The set of Penitentiary Regulations laid down in 1899 continued to remain in effect, with its emphasis on retribution unaltered.[1] In 1921 a committee appointed by the Minister of Justice, for the purpose of advising on the revision of these regulations and on the amendment of the Penitentiary Act, gladly reported that in no institution was this prescribed regimen followed. "The divergence from the principle of the regulations varies from institution to institution, and its extent depends upon the personality of the warden and the spirit he instills into his staff."[2] None of the penitentiaries strictly adhered to the rule of silence, with the limits on conversation by convicts varying among the institutions. A lack of enough suitable work for convicts continued to persist, though at the institutions that were under construction the morale of convicts was much better than at those where this work could only occupy the time of a minority. Useless occupations such as stone-breaking by hand still took up the time of many.[3]

The report of the committee focussed on the need for the penitentiary system to prepare the prisoner for his return to society, to prevent him from being "deteriorated by the punishment he had undergone," and to enable him to maintain family ties as far as was practical. It recommended that the main direction of the office of the Superintendent of Penitentiaries be towards "development and cure" instead of "repression and restriction"; that "modern scientific resources" be used in the examination and classification of convicts so that their curable physical and mental illnesses might be overcome; that remunerative and productive labour be provided for all convicts; and, finally, that parole be promptly granted when a judicious examination of the case warranted it.[4] But the report of this committee seems to have had little impact at all on the penitentiary system, apart from improvements in hospital conditions, of which the committee members were very critical.

During the 1920s the Canadian penitentiary system thus continued to retain its nineteenth century character. Its regime was repressive and secretive in nature.[5] But the ordeal of the first World War had gravely weakened the structure of nineteenth century civilization. From Canada it had exacted a terrible toll of over 60,000 soldiers killed, and national unity had been dealt an appalling blow by the long and fierce debate over conscription. In this decade a secular society replaced one governed by blind fundamentalism. It was also a decade of economic transition, from post-war prosperity and inflation to the sudden depths of the worldwide economic depression which followed the crash of the New York stock market in September 1929.[6] By 1930 it was thus "a very different country in aspiration, thought, and deed" than the Canada of 1914.[7] Soon these changes would affect Canadian penitentiaries.

As the spectre of economic depression gloomily pervaded the country, criminal activity rose and the population of Canadian penitentiaries soared dramatically. In 1929 there had been about 2,700 convicts imprisoned in these

institutions; three years later this figure had jumped to over 4,000 convicts.[8] The result was overcrowding at every penitentiary and an escalation of tensions between the convicts and the prison authorities as conditions inside worsened. Although there had been a serious disturbance, if not a riot, at the Kingston Penitentiary in 1927, the tempers of convicts certainly did burst in 1932.[9] Trouble broke out at Kingston in October when convicts rioted once and caused several disturbances afterwards. The result was almost $4,000 in damages.[10] That same year a riot and fire at St. Vincent de Paul Penitentiary caused about $70,000 in damages.[11] This disturbance had been touched off by the cancellation of paper for rolling cigarettes.[12] Another riot occurred in 1935 at the Manitoba Penitentiary, sparked by the violent assualt of an inmate upon an officer. During the émeute an officer shot and killed a convict, with a bullet intended for another convict.[13]

The riots and disturbances in Canadian penitentiaries in the early 1930s caught the attention of the public. It was obvious that not all was well within the gaunt walls of these institutions. This impression was amplified by the public trials of the rioters, where the evidence presented made some outside observers believe that the convicts were prompted to riot by "some sense of injustice." An official report stated in 1933 that the main causes of the riots in 1932 "were insufficient inspection and supervision during a period of ten years, a lack of knowledge of penitentiary rules on the part of the staff, and on the side of the convicts, the rigour of rules and their strict enforcement had stirred some long-term convicts into subordination."[14] Beginning in January 1933 steps were taken to lessen the sternness of the penitentiary regulations. Convicts were now allowed to talk with each other before going to work in the morning, at lunch time, and up to seven o'clock in the evening while confined in their cells. Well-behaved and industrious convicts could now visit monthly with relatives, instead of only bi-monthly. Letter writing for well-conducted

convicts was also increased, from one letter to two each month. Another innovation, introduced in January 1935, was an allowance of five cents per day for convict labourers.[15]

These ameliorative measures may have deflected some criticism away from the Department of Justice and its administration of the penitentiary system. However, the cry for penal reform was from silenced. More pressure for change was added by much publicized stories of what really was happening behind the tall and austere walls of Canadian penitentiaries. Life inside was governed by a prison routine "in no way constructive, but rather repressive in character, tending to make a man neutral and dumb in his mentality if he wanted peace."[16] One of these accounts was by Dr. O.C.J. Withrow, a convicted abortionist. His remarkable story of life at the Kingston Penitentiary was published in serial form by the Toronto Globe and also as a book, titled Shackling the Transgressor.[17] For example, he spoke of some of the guards as an incompetent and sometimes brutal group of people.

> I should like to tell you anecdotes of some of the guards; about 'Lightning Rod', mentally unsound, cruel and vindictive, zealous for officialdom, who at a word from a convict unwound the blanket-covering from a phonograph being returned to a downtown merchant because it was suggested to him that one of the boys might be curled un inside trying to make a get-away; of 'Happy Harry' who walked so straight that he leaned backwards, and was a 'rat' of specially huge dimensions; of the 'Admiral' who loved to 'write up' men on what were known colloquially as 'duckets' and who came in one day waving a bunch of these papers, crying "I wrote up eighteen to-day and I'll get twenty-one of the birds tomorrow["];...about the guard who was too drunk to climb up into his cage on the range to watch the boys file past but from his place on the floor wrote up a man for 'dumb insolence'; and of D___, the paddler, who one of his off-days, when escorting a few of his friends through the hospital, slapped me on the back and introduced me as one of his best friends. But time and space forbid.[18]

Even though the federal Government was then trying to minimize the issue of the maladministration of Canadian penitentiaries, attributing the riots and disturbances to the work of a few agitators, the problem would not go away.

Heated debates took place in 1934 and 1935 in the House of Commons as the ruling Conservative party faced strong demands from the Opposition parties for the appointment of a Royal Commission into the management and state of affairs at Canadian penitentiaries. Church groups and other bodies advocating penal reform also added their voices to this clarion call. But penitentiary officials and some Parliamentarians were staunchly opposed to the proposed investigation. In the end it took a pledge by the Opposition party--the Liberals--to call such an inquiry if they were elected.[19] This commitment was honoured when they came to power in 1936, after having defeated the Conservatives who were divided over the wide-ranging reforms of Prime Minister R.B. Bennett's 'New Deal' program.[20]

Over the next two years this Royal Commission, headed by Judge Joseph Archambault of the Superior Court of Quebec, exhaustively investigated the penal system of Canada. Its 418 page report contained eighty-eight recommendations for penal change and was a turning point in the history of Canadian corrections. The three Commissioners acknowledged the difficulty of formulating principles of penology to be followed. Penology was still the subject of much scientific study; at the same time it was marked by controversy and many of its problems appeared to defy practical solution. Nevertheless the Archambault report identified the protection of society as the fundamental basis of penology, to be achieved by emphasizing the prevention of crime and the rehabilitation of the prisoner. The Commissioners regarded the responsibility of society to reform and rehabilitate the criminal as one which had not been effectively implemented, although it had been recognized for nearly a century. It was to this task that the Commissioners directed their recommendations. In their optimistic view the problems of the penal system could be remedied, but only if its ills were identified and the appropriate cures instituted.[21]

A large part of the Archambault report was taken up with a harsh indictment of the management of the penitentiary system under the Superintendent of

Penitentiaries. Since the appointment of General D.M. Ormond in 1932 many of the problems plaguing the system could be directly attributed to him. Ormond was found to be "arrogant" and "neglectful," in addition to employing "extreme dictatorial methods." His annual reports to the Minister of Justice deserved equally harsh censure, being "gravely misleading in important matters affecting penitentiary management." Furthermore, the Superintendent chose to exercise "a centralized control of minor and even trivial matters of administration in individual penitentiaries," with the result that the authority, power of initiative, and effectiveness of the inspectors and wardens under him was destroyed.[22]

An example of the despotic managment of the Superintendent of Penitentiaries was the implementation in 1933 of a new set of Penitentiary rules and regulations. The 724 new rules and regulations, plus ten appendices, covered in great detail all matters regarding the administration, policy, and discipline of Canadian penitentiaries. However, the drafting of these rules was done without consulting any of the wardens. Such arbitrary measures only served to take up much of the time of penitentiary officials and militated against effective cooperation between the Superintendent's office and the institutions.[23] Understandably the Commissioners called for the immediate dismissal of Superintendent Ormond, and he left the penitentiary service in 1938.[24] The major reforms, though, that the Commissioners called for were delayed by events taking place far beyond Canadian borders. When another World War broke out only two decades after the last one, the attention and resources of Canadians were once more focussed on a European war. Penal reform would largely have to wait until the end of the second World War in 1945.

Medical Services

In the era between 1915 and 1938 increasing attention was devoted to the upgrading of penitentiary medical services. Hospital accomodation was one area

where improvements were particularly needed. In 1921 the committee which studied the revision of the Penitentiary Regulations and the amendment of the Penitentiary Act was very critical of the inside cell block design adopted in Canadian penitentiary hospitals.

> In all of them visited by the Committee the hospitals follow the general type of construction adopted for the main portion of the penitentiary and have therefore what are known as "inside cells" opening on a wide corridor which intervenes between their barred doors and the windows of the building, these being of course also barred. The result is that sick convicts cannot easily receive sunlight or adequate fresh air and are generally so placed that while in bed they face the cell door and the windows beyond, a position which in a [sic] case of many diseases must be particularly irritating to the patient.[25]

Improvements in this area were soon forthcoming. During the 1920s permanent prison hospitals replaced temporary facilities at the Dorchester, St. Vincent de Paul, Saskatchewan, and British Columbia penitentiaries.[26] These new facilities were regarded by the Superintendent of Penitentiaries as a great credit to the Department of Justice. In his annual report for 1924 W.S. Hughes published a number of letters which praised the administration of Canadian penitentiaries. In one, a federal official who investigated the treatment of venereal diseases at the three eastern penitentiaries described the hospital quarters at Kingston as "attractive, comfortable, and spotless." A similar comment applied to St. Vincent de Paul, while at Dorchester the hospital conditions were inadequate but soon to be remedied by the completion of the "splendid new hospital section." A Halifax physician also lauded the new hospital quarters at Dorchester, saying that they were equal to those in a new wing at the major hospital in his city.[27] A year later, at a convention of his wardens, the Superintendent acknowledged the improvements made. He stressed the importance of proper hospital care because it would greatly impress the ill convict and materially contribute to his reformation.

> You have all improved your hospitals very very much, but do not desist; keep on. No matter whether a man has trangressed, let us teach him the way to live. There is no time you can influence him like when he is sick. See that your Chaplains visit the men in hospital daily, and read to them if the Physician allows it.[28]

Yet the high quality of medical services claimed by Superintendent Hughes is open to considerable doubt, particularly in regard to the Kingston Penitentiary. In his memoir of convict life there in the late 1920s and early 1930s Dr. O.C.J. Withrow painted a shocking picture of the backwardness of medical services at the institution.[29] He was especially scornful of the conditions under which hospital operations were carried out.

> In order to make our operating-room still more of a show-place for visitors, a gas and oxygen apparatus was purchased, costing between four and five hundred dollars...For a year this beautiful bit of apparatus for the administering of anesthetics stood in all its glory in the operating-room. It was moved in and out on cleaning days, but while I was there, it was never used for the purpose for which it was intended. Its sole value was to impress that portion of the public permitted to view the efficiency of the system, with the splendid appointments of our operating-theatre...Major work was always in the hands of a visiting surgeon. The prison physican limited himself to the simplest of minor surgery. The visiting surgeon is always an expert in the craft, and is usually changed with a turnover in the Government at Ottawa. His fees are certainly not large, but his technique is the best that can be given. The results are astonishingly good in face of the dilatoriness in diagnosis and the difficulty of securing permission to call in the operator. For I am prepared to say, after a fairly long period of observation, that hardly a necessary surgical operation is performed until the patient is almost <u>in extremis</u> and is practically ready for the beckoning finger of the angel of death.[30]

Perhaps in response to such harsh criticism as well as to the obvious need for financial retrenchment during the Depression years of the 1930s the Deputy Minister of Justice sought out the advice of the federal Department of Pensions and National Health in June 1933. This was done in the interest of "effecting economies, if possible," in the provision of penitentiary medical services.[31]

The latter quickly undertook a general review and survey of these services. In early July it reported that much could be improved. In certain cases penitentiary physicians appeared to be wanting in the knowledge or application of modern medical procedures. The result, to some extent, was too many consultations--involving large expenditures--with outside specialists. Another finding was that the quality of medical services varied considerably among the institutions. This situation was attributed to the fact there was no general supervising medical officer at penitentiary headquarters in Ottawa. It was recommended that this post be established. The employment of outside specialists also needed closer watch. Not only were these services paid for "in various amounts without any uniformity or definite schedule of fees," but the Penitentiaries Branch was overbilled in many instances. The recommended solution to this problem was to supply doctors from the staff of the regional offices of the Department of Pensions and National Health, although for such isolated penitentiaries as Dorchester and Saskatchewan the assistance of local specialists would have to be obtained by the penitentiary medical officer. Billing for the services of outside specialists would take place through this Department.[32]

The brief investigation by the Department of Pensions and National Health also touched upon the hospitalization of convicts and on the condition and supply of medical equipment, supplies, and facilities. The use of community hospitals, which was at higher rates than those between these institutions and this Department, was discouraged except where approved by its District Medical Officer and in emergency cases. Medical equipment, supplies, and facilities was another area needing improvement. Much of the material was either not in use or was worthless.[33] At the Kingston Penitentiary there was so much surplus surgical gauze from the first World War that this expensive item was used for general cleaning purposes in the hospital.[34] A complete inventory of medical equipment and supplies was necessary in order to redistribute or destroy surplus equipment.

And future supplies needed to be bought on a centralized basis by the Department of Pensions and National Health, instead of part locally and part at Ottawa.[35]

Over the next several months extensive discussions took place between the two Departments regarding these proposals. In September 1933 the Minister of Justice rejected these changes pending further study by the Civil Service Commission. Nothing more in this respect appears to have been done, although the Department of Pensions and National Health continued to advise the Superintendent of Penitentiaries on penitentiary medical services.[36] Five years later the report of the Archambault Royal Commission again pointed to the need to upgrade these services, after it had had the chance to make a more thorough examination than the Department of Pensions and National Health.

The Archambualt Royal Commission found that the quality of penitentiary medical services varied considerably between institutions. It ranged from good to poor, depending on the character and qualifications of the physicians at the institution. The existence of modern hospitals at some penitentiaries was in sharp contrast to other prison hospitals which were regarded as inadequate and antiquated.[37] At the St. Vincent de Paul Penitentiary its hospital with thirty-one cells was clean and well-kept, but too small for the more than one thousand prisoners.[38] In comparison, the hospital at the Kingston Penitentiary had withstood the passage of time since it was opened in 1853. It was "untouched in its essentials by progress in the fields of medicine and surgery and only improved at all in its equipment."[39] The best situation was at the British Columbia Penitentiary, where the new hospital, opened in 1923, was used neither to house seriously ill convicts, nor for surgical cases. They were instead removed to the local hospital at New Westminister, where the cost of their treatment was paid for by the Department of Justice. Besides the lower cost involved the treatment received by convicts was of a better quality.[40]

Another finding of the Archambault Royal Commission was that the services of some of the penitentiary physicians were far from satisfactory. At the St. Vincent de Paul Penitentiary the doctor gave inadequate attention to the medical examination of new or complaining covicts, conducting these in a cursory manner unless a convict said he had a specific problem. Even worse, he considered many convicts to be malingerers, particularly those who were convicted of certain crimes. There were two unfortunate cases where convicts complaining of chest pains later died of appendicitis.[41] Insufficient medical examination at the time of the convict's reception was also a problem at the Kingston Penitentiary. As well no regular medical checks were made on the prisoners. Its basically kind physician had become "too institutionalized." The Commissioners believed that this inflexibility was the product of the criticism he had received for the large number of special diets and exemptions from heavy labour which he had sanctioned in his first years there after being appointed to the post in 1929. They noted that prisoners injured in rioting at the institution were in many cases treated brutally, and were refused proper diagnosis and treatment. Many convicts there complained to the Commissioners about neglect and punishments for malingering, but the majority of the complaints made were regarded as the product of petty grievances and detected malingering. And like other physicians and dentists in the penitentiary service, the job of this medical officer was burdened down by the "unnecessarily voluminous correspondence" with the Superintendent of Penitentiaries over the authorization of treatment for convicts by outside doctors and specialists.[42]

Understandably a number of the recommendations made by the Archambault Royal Commission concerned penitentiary medical services. It was stressed that a high standard of medical care was required because it had a rehabilitative value, besides its obvious humanitarian value. To this end medical treatment involved both the physical and mental health of the prisoner; consequently, the addition

of a psychologist or a psychiatrist to each Canadian penitentiary was needed in order that a thorough physical and mental examination could be made of each prisoner. The surgical correction of physical defects was another way in which the rehabilitation of the individual prisoner could be aided. A modern and sanitary hospital with wards instead of cells, except for unmanageable patients, was another need at each institution. Separate wards were recommended for tuberculosis and venereal disease cases and for those under observation for mental illness.[43] These recommendations heralded a new emphasis on prison health care, where instead of simply maintaining the health of the prisoner his proper physical and mental well-being were seen as part of the whole approach to his rehabilitation.

Apart from the continuing inadequacy of penitentiary medical services in Canada, this era did see a number of important developments take place in this area. Influenza and venereal disease followed in the war's footsteps while the age-old problem of the care and treatment of insane convicts continued to pose difficulties for penitentiary officials. In addition, attention was now given to the problems of tubercular convicts. Also significant in this period is the introduction of penitentiary dental services in 1923.

Of all these developments, influenza was the shortest-lived. Its appearance in the fall and winter of 1918-19 marked the first time since 1854, when cholera had appeared at the Kingston Penitentiary, that a worldwide pandemic had taken a heavy toll of convict lives. It was brought to Canada by soldiers who were returning home from Europe. They carried a new strain of influenza with them, nurtured in crowded army camps and on muddy battlefields, which proved to be more virulent than any previously seen form of the disease. During the nineteenth century alone it had appeared in major epidemic proportions at least six times--in 1800, 1830, 1843, 1857, and 1889-1890. This new strain was considerably different because it had a high morbidity and a much higher

mortality rate. In this pandemic the former ranged from 15 to 50 per cent in various countries while about one per cent of those infected died. It is estimated that the pandemic killed about twenty-two million people around the world. The only inhabited place in the world to escape its ravages was the tiny island of Tristan da Cunha, 1500 miles south of St. Helena in the Atlantic Ocean.[44]

A mild form of influenza had appeared in Canada and the United States in the early spring of 1918, but it was not harsh enough to divert any energies away from the war effort.[45] At the Kingston Penitentiary this outbreak persisted for about ten days.[46] It was in July of 1918 that the returning troopships first brought the more virulent form to Canada. During the summer the contagion seems to have spread slowly. But by the end of September it was clear that the country had a major problem.[47] Six of the seven penitentiaries were attacked by the contagion, with some faring better than others. Dorchester Penitentiary was hard pressed with four deaths from the 107 cases among its 179 convicts. Hit much worse was the St. Vincent de Paul Penitentiary. Twenty-one of its 399 convicts fell victim to the disease.[48] Kingston Penitentiary prepared for the onslaught of influenza in early November, laying in a stock of serum and setting aside the Prison of Isolation for use as an isolation hospital.[49] Fortunately they escaped the epidemic then, though it later returned in a less virulent and non-fatal form. On that occasion a few of the numerous cases were judged to be serious but, as the Warden reported, they received excellent nursing care.[50]

The epidemic was spread westward by apparently healthy soldiers returning home on the railways. By October 18th it had reached Edmonton.[51] In Western Canada only one institution escaped infection. No cases at all occurred at the Saskatchewan Penitentiary. There a strict quarantine was adopted and enforced regarding the attendance of officers and visitors as well as the segregation of newly-admitted prisoners. At the Manitoba Penitentiary about half of the

ninety-eight convicts were stricken by influenza, but luckily there were no deaths. It was not the same story at the Alberta Penitentiary. Of the hundred cases among the 129 convicts, six were fatal. Similarly, eighty-four of the 161 convicts at the British Columbia Penitentiary became ill. Five convicts died and the normal routine of the institution was disrupted, with twelve officers ill, the prison school suspended, and the work of the chaplains increased. All told, thirty-six of the 1468 convicts imprisoned as of March 31, 1918 fell victim to this very virulent strain of influenza.[52] In comparison to this mortality rate of about 2.5 per cent, it has been estimated that at least 50,000 Canadians, or about .7 per cent of the estimated just over eight million inhabitants of the country, perished from the same cause.[53] Fortunately such a virulent epidemic has not again run rampant around the world.

Influenza was not the only infectious disease Canadians had to cope with in the post-war years. Venereal disease, hitherto a sensitive topic generally not publicly discussed, gained the attention of social reformers and the public because it was a major problem for Canada's military forces. Previously concern over gonorrhea and syphilis had rested with the medical profession. But by 1916 Canadians had become aware of the high incidence of venereal disease among recruits and of the growing number of cases among the enlisted. This problem threatened the national defence by immobilizing Canadian manpower.[54] In Europe alone, the Canadian army was faced with 66,083 cases among the 418,052 troops sent overseas.[55] Syphilis and gonnorhea combined made up twelve per cent of all illness among the military, apart from wounds. And this rate seemed to parallel that of the general Canadian population. In 1917 a survey of all new admissions to the Toronto Gneral Hospital revealed that syphilis made up 12.8 per cent of the cases.[56]

Action was taken during the war both at home and overseas in order to prevent the spread of venereal disease to soldiers especially and among the

general population. In Canada, for example, it was made illegal in 1917 for any woman suffering from a communicable form of venereal disease to have sexual intercourse with any soldier or to solicit or invite him to do so. Detention and treatment for the disease was the penalty for this offense. Much of the attempt at prevention was aimed at curbing the activities of prostitutes and loose women. Groups such as the Young Women's Christian Association established hostess houses at the various military camps. These were chiefly recreation centres, where soldiers could meet suitable women who were not out for mercenary or physical gain.[57]

Yet these schemes to prevent illicit sexual intercourse did not effectively attack syphilis and gonnorrhea as health problems that generally affected the whole of Canadian society, not just its soldiers. It remained for public health reformers to provide the impetus for a more thorough campaign against venereal disease. Reports about the prevalence of venereal disease in the general public and revelations about the extent of prostitution in Canadian cities led many groups to believe it was a very serious menace to public health.[58] The ravages of the war amplified these concerns, for the sterility produced by some cases of venereal disease could not help in making up the population losses incurred in the conflict. In addition, social reformers saw a clear link between venereal disease and feeblemindedness. Not only did it add to the infant mortality rate, but it caused a number of children who were strong enough to reach adulthood to be mentally defective. It was therefore argued by social hygiene reformers that the eradication of venereal disease would prevent feeblemindedness and remove this burden on society. Concern was also voiced at the time over foreign mental defectives allowed into Canada because of lax medical examinations by immigration authorities.[59]

With these closely related factors in play, the medical profession called for a coordinated national effort to be led by the federal government--with the

assistance of provincial legislation--against venereal disease. Together with major concerns about feeblemindedness, tuberculosis, and infant mortality, the control of venereal disease was thus a major factor in the establishment of the federal Department of Health in 1919. One of the ten divisions of the new department was devoted to disease control. Its $200,000 budget was designed to supplement provincial expenditures in the campaign against venereal disease. This campaign aimed at providing effective treatment, chiefly through free public clinics for sufferers, and at the education of the public. The latter task was an attempt to ensure the infected came forward and that the remainder fully recognized the problems of venereal disease and would act accordingly. One of the conditions for the provinces if they were to receive this federal funding was the treatment of all incarcerated persons.[60] The result was the introduction of up-to-date venereal disease treatment in Canadian penitentiaries.

Prior to the 1920s "practically nothing" was done for the treatment of venereal disease in Canadian penitentiaries.[61] There had always been convicts who had suffered from this malady, but in the nineteenth century the social taboo against the disease and the lack of effective medical treatments meant that these cases were infrequently commented upon in the annual reports of penitentiary physicians. Instead, syphilis or gonorrhea were usually mentioned only in the appended lists of hospital or dispensary cases in these reports. Two exceptions, though, came in 1901. The physician at the Kingston Penitentiary, Dr. Daniel Phelan, noted that a large number of convicts were afflicted with syphilis. He called it "the direful spring of woes unnumbered." In his institution treatment for it started upon the reception of the convict, a practise "which has the effect of keeping those afflicted in good health and of arresting the progress of the disease."[62] The surgeon at the Manitoba Penitentiary, Dr. R.W. Neill, commented about how syphilis contributed to the high drug costs of the institution.

> To this prison come a large number of men suffering from syphilis in one or other of its stages, necessitating constant treatment. Amongst physicians it is known that the drugs used in the treatment of this disease are costly, and that to be of any use treatment must be continued for a long time, about three years. It is easy to see that if the patients suffering from this disease and those suffering from tuberculosis receive proper treatment, the per capita cost will be larger than would otherwise be expected.[63]

Unfortunately the treatment given to these afflicted convicts at the turn of the century was flawed in a number of respects. At this time the armamentarium of the physician in the treatment of venereal disease consisted of mercurcy therapy. It was sometimes curative in the early stages of the disease, or could arrest it in its later stages. However, this was a very painful experience for patients, and for some was even fatal. Because mercury was toxic to human tissues physicians often found it difficult to determine the correct dosage. Among the toxic effects which could be produced by an overdose were profuse salivation, anemia, mental changes, diarrhea, loosening of the teeth, and damage to the kidneys with subsequent renal failure. Not until 1907 was an effective and safe treatment for syphilis discovered, in the form of Salvarsan, a less toxic arsenical compound than mercury.[64]

Diagnosis was the first step in the treatment of convicts with venereal disease. Wasserman tests for syphilis were introducted at each institution in the early 1920s.[65] While this blood test could definitely establish the presence of syphilis, its use initially encountered some resistance from convicts. At the St. Vincent de Paul Penitentiary, where in 1925 sixteen per cent of the convicts had syphilis, the shame and the fear of taking treatment for it prejudiced convicts against Wasserman tests. However, the cures obtained by treatment for the disease gradually wore down this resistance and convicts increasingly submitted themselves to treatment for the disease.[66] In just one case there did

convict refuse to take a blood test, in which event the Department of Justice decided that this treatment did not comprise an operation and could, therefore, be regarded as compulsory.[67]

Part of the evident stigma attached to venereal diseases at the St. Vincent de Paul Penitentiary may have been caused by the fact these convicts had to wear a distinguishing black cross on their clothing. This mark would warn onther convicts that its bearer was diseased as well as enabling the clothes of the infected convict to be washed separately. This practice was started in 1923, and two years later was extended to the other penitentiaries.[68] Other measures were also in place in order to prevent the spread of venereal disease. In 1924 an official of the Department of Pensions and National Health examined, at the request of his own Department, the facilities for venereal disease treatment in the penitentiaries at Dorchester, St. Vincent de Paul, and Kingston. He reported that convicts in an infectious stage of the disease were isolated from the others and that their clothing, dishes, and utensils were kept apart and washed separately from those of the other convicts. This report also stated that the treatment facilities at Kingston and St. Vincent de Paul were modern, although at Dorchester conditions in the old and soon-to-be replaced hospital made it difficult to give adequate treatment.[69]

In 1929 the Superintendent of Penitentiaries was able to report in a memorandum to the Deputy Minister of Justice that all the penitentiary surgeons were very active in treating venereal disease. "Wonderful success," he stated, "has resulted in connection with this treatment."[70] Some inmates, though, were not as enamoured of the quality of treatment as was Superintendent Hughes. Many complained after the Kingston Penitentiary riot in 1932 that they had to use the same tableware as used by convicts with venereal disease. The charge was denied at the time by the penitentiary physician.[71] This denial was repeated by the Minister of Justice when the matter was later raised in the House of Commons in

July of 1934 by Agnes Macphail, the Co-operative Commonwealth Federation Member of Parliament whose main interest was prison reform.[72] The Archambault Royal Commission referred to the subject of venereal disease in its report in 1938, but only to recommend that separate wards should be used for these patients.[73]

However, apart from the convict complaints about inadequate precautions against the spread of venereal disease at the Kingston Penitentiary, there seems to have been ltttle attention devoted to this problem in the 1930s. The same sense of urgency which prevailed in the immediate post-war years no longer existed.[74] The general public apathy about venereal disease apparently extended to the penitentiaries as the subject was infrequently discussed in the annual penitentiary reports during this decade. Penitentiary surgeons also had to deal with fewer cases of venereal disease.[75] For the most part this public apathy was due to the general rejection of wartime worries which characterized much of the 1920s. And to some degree this loss of interest was also due to the moralizing nature of the venereal disease propaganda sponsored by the social hygiene reformers, in the form of public lectures and in literature on the subject. Not surprisingly, venereal disease did not again become a matter of public and governmental concern until the second World War, which "once more advertised the problem of maintaining a healthy civilian and military work force."[76]

Another infectious disease which received more attention in this era than previously was tuberculosis. During the period from 1916 to 1926, for which a survey was taken in 1926 by the Superintendent of Penitentiaries, there were 174 cases recorded among a convict population averaging about 2,200 for the ten years.[77] However, it is possible that in actuality there were more tubercular convicts than this number would indicate. An investigative survey of health care in American prisons, jails, and reformatories which was published in 1929 noted that the number of reported cases was about half that of the general population. Prison doctors offered several reasons to account for this fact. Besides the

beliefs that most prisoners were free from infection and that the regular routine of penal life led to an improvement in their health, it was believed that at the time of their commitment the tubercular lesions in the lungs might not be acute and would therefore escape detection during the physician's medical examination of the new prisoner. The investigators, however, were of the opinion that the failure to detect the disease in its early stages was related to the lack of sufficiently exact examination methods to discover all cases admitted. In only one American prison, in New Jersey, was a chest x-ray taken of all newly-admitted prisoners.[78]

The presence of tubercular convicts could pose trying problems for penitentiary officials. Of particular concern to wardens was the need to release them early if it became clear that their illness was terminal. Securing authorization from penitentiary headquarters in Ottawa was a time-consuming process, especially for officials at the British Columbia Penitentiary. Its many Native prisoners were particularly susceptible to the disease. In one case in the 1920s it progressed so rapidly that the authorization for parole arrived only hours before the convict's death. And by that time he was, for all purposes, dead.[79] Another problem related to the admission of tubercular convicts. In some Ontario county jails and throughout the Maritimes there was not proper accomodation for prisoners afflicted with contagious diseases. On several occasions prior to April 1922 the Department of Justice complained to the various provincial attorney general's departments about this matter, but these authorities did not regard it their duty to provide proper quarters for such cases. The result was a very difficult problem, and in a number of cases these prisoners had to be treated under guard in a local hospital.[80] In one unusual case the transfer of a prisoner from Prince Edward Island to the Dorchester Penitentiary was twice refused before it was accepted. The first time it was because he had the disease, as the provincial authorities stated. The second

time he was supposedly cured but the penitentiary surgeon found otherwise, and the man was returned to Prince Edward Island. He was only accepted the third time because it was ordered by the Minister of Justice.[81]

Special accomodation was not set aside for tubercular convicts in any of the penitentiaries across the country, apart from lodging them in the prison hospital at each institution. In 1935 the Superintendent of Penitentiaries noted in a memorandum to the Deputy Minister of Justice that this was an inadequate practice, for what was in fact needed, in line with current opinion on the treatment of the disease, was isolated hospital cells with abundant natural light. It was also his opinion that tubercular convicts caused more problems than all other diseased convicts.[82] Sanitorium conditions could obviously not be duplicated because of the limitations of the inside cell block design adopted in the prison hospitals across Canada. The seriousness of this problem was revealed by the report of the Archambault Royal Commission in 1938. It was shown that hospital conditions varied greatly among the penitentiaries. At the Dorchester Penitentiary the situation was somewhat satisfactory, with cells for both ordinary and tubercular patients located on the third floor, and a small solarium provided for the latter group.[83] These conditions compared very favourably to those at the St. Vincent de Paul Penitentiary. There tubercular convicts were allowed only two hour's use of the sun room each day. In addition, the medical examinations of these convicts were superficial, and in some instances, convicts with active cases of the disease were declared as fit for work. For those sent to work in the stone-shed at the penitentiary, the most gruelling labout at St. Vincent de Paul, the Commissioners declared that "it was equivalent to a sentence of death."[84]

The situation in the penitentiaries in Ontario and in Western Canada was not as bad as at St. Vincent de Paul. At the Kingston Penitentiary an equally deplorable but not so horrific state of affairs existed. The ancient prison

hospital had no sun room which might have eased the sufferings of these patients, who were housed, together with other prisoners, in dark and gloomy cells bereft of sunlight and fresh air.[85] In his memoir of convict life at the penitentiary in this era Dr. O.C.J. Withrow claimed that "Many a tuberculous patient has succumbed to his malady amid the semi-darkness and fetid atmosphere of such quarters."[86] Moreover, the lack of sanitation in the hospital, as evident in the absence of toilets in the cells and the lack of a proper place for washing dishes, probably caused other prisoners to be infected with the disease.[87] In Western Canada only the Saskatchewan Penitentiary came under the censure of the Commissioners. Its hospital had no facilities for treating serious cases of the disease, with two of these moribund patients presenting "a pitiable spectacle" to the visiting Commissioners.[88] After having seen the sometimes deplorable care of tubercular convicts in Canadian penitentiaries the Archambault Royal Commission recommended that separate wards be provided for these cases.[89] However, starting in the 1940s a different course of action was followed. After detection active cases of tuberculosis would be removed as soon as possible to a sanatorium, except in exceptional cases and then according to the nature of the convict's crime.[90] Yet while this expedient was a practical one, especially because of the manifest inadequacy of some of the penitentiary hospitals, it would not prove to be a trouble free one.

Convicts suffering from tuberculosis and venereal disease certainly were serious problems at Canadian penitentiaries. However, the worst difficulties were experienced in the care and treatment of insane convicts, as had generally been the case since the opening of the Kingston Penitentiary in 1835. After the removal in 1915 of the forty-odd convicts from the asylum at the Kingston Penitentiary to provincial mental hospitals, it took only a few years for new problems to appear regarding their care and treatment. In early 1918 provincial authorities in Quebec, who had previously not hesitated to accept these convicts,

refused any further transfers and asked that some of those already under its charge be returned to the St. Vincent de Paul Penitentiary. As a result five insane convicts were lodged in the basement of the penitentiary, under shocking conditions, until the Superintendent of Penitentiaries intervened in 1918. He successfully negotiated the placement of four of them in Quebec mental hospitals, while the fifth, whose transfer was refused, was sent to an Ontario mental hospital. In 1921 the Quebec government again refused the transfer of insane convicts, leaving the penitentiary authorities to cope with these convicts.[91] In one particular case, between 1923-24, it took five months of persistent effort by the Warden and the Superintendent of Penitentiaries to effect the transfer of the convict to a Quebec mental hospital. During those five months the prisoner had remained in his cell, in a naked state and surrounded by the debris of his clothing and a mattress which he had torn to shreds.[92]

The problem of removing such convicts from the St. Vincent de Paul Penitentiary to a provincial hospital in Quebec was only solved when the two governments came to a verbal understanding at some time in the early 1920s.[93] Yet the problems in the management of this class of convicts were not limited to this institution. By 1923 the provinces of Alberta, British Columbia, and Manitoba were also rfusing at times to accept these convicts into their mental hospitals.[94] Penitentiary officials in the institutions were powerless to deal with the situation. Again penitentiaries had to put up with the disruptive effect of the insane. Unable to be adequately cared for or isolated, the noise made by these prisoners disturbed the rest of other prisoners.[95]

Further problems also attended the new practice of transferring the care and treatment of insane convicts to provincial authorities. The proper security of the provincial mental hospitals proved to be a problem. In the fiscal year 1920-21 five convicts had simply walked away from these insitutions and, all the worse, some of them were considered to be dangerous criminals.[96] The maintenance

of these convicts was not cheap either, and the cost was more than that of the former insane asylum at the Kingston Penitentiary.[97] As well the practice could be abused by the provinces. In one case a convict had been deported but the Department of Justice, unaware of this action, had paid for his care for more than a year afterwards. In another case it was thought by the Superintendent of Penitentiaries that the maintenance paid for another convict should be refunded as he had long performed the duties of an officer at some of the provincial government institutions.[98]

In view of such problems, it is not surprising that during the 1920s penitentiary officials argued that the obvious solution to these difficulties was to re-open the insane asylum at the Kingston Penitentiary. The chief promoter of this change was W.S. Hughes, the Superintendent of Penitentiaries from 1918 until 1931. When the decision to close this facility had been taken in 1915 Hughes (then the Assistant Inspector of Penitentiaries) was absent overseas, serving with the Canadian military forces in Europe.[99] Until his retirement in 1931, after nearly forty years in the penitentiary service, he continually proclaimed the need for a criminal insane asylum to be maintained by the federal Government. In his view, as he stated in a memorandum to the Deputy Minister of Justice in 1923, the closure of the Kingston Penitentiary asylum was "one of the most grave mistakes made in connection with the management of Penitentiaries during my term of thirty years in these institutions." He saw nothing wrong with the previous arrangements, both in respect to the care and treatment of the insane and to the adequacy of these quarters.[100] Also in his opinion the convicts were in no cases treated any better at these institutions, and in most cases not as well as in their former locale.[101] His views were echoed by the penitentiary wardens at their 1929 convention, when they resolved unanimously that the Dominion establish a "mental disease hospital."[102] But this request to the Minister of Justice evidently fell on deaf ears, with the Government perhaps not wishing to duplicate the politically explosive problems which had been

produced by the former system. A return to the custodial care and treatment of the insane was not to take place.

With the retirement of Superintendent Hughes the agitation for the Department of Justice to operate a criminal insane asylum seems to have ceased. His successor, D.M. Ormond, found the existing practice satisfactory because the pentientiaries were not equipped to handle these cases, as well as in respect to economy and to the best treatment of these convicts.[103] Nor were any problems experienced in obtaining the service of outside psychiatrists for the certification of insane convicts. In 1936, for example, a total of sixty-eight insane convicts were being maintained at federal expense in provincial mental institutions.[104] However, during the 1930s there continued to be some serious problems in effecting the transfer of insane convicts to provincial mental hospitals. These difficulties were discussed at length in the report of the Archambault Royal Commission in 1938. It endorsed the existing practice, but stressed the importance of securing a better working arrangement between the federal and provincial authorities.[105]

To illustrate these remarks the Commissioners described the cases of three insane prisoners. In the first case the convict was both demented and suicidal. A murderer imprisoned for life, he had been in the Alberta and Saskatchewan penitentiaries respectively since 1912. In November 1936 the penitentiary medical officer declared that the convict was insane and should be sent to a mental hospital. He did not belong in a penitentiary. Not only was it an undue hardship for him, but it was also an injustice to the prison authorities and to other convicts. However, the Alberta Government refused to accept the convict into its care. It cited the severe over crowding of its two provincial mental hospitals, and its belief that these institutions should not be expected to provide facilities for the care and the treatment of the criminally insane. The federal Government claimed that the province was obligated (because health care was a provincial responsibility under the British North America Act of 1867) to

care for insane persons, regardless of whether or not they were criminals. However, the provincial authorities simply ignored this declaration, and the convict remained in the Saskatchewan Penitentiary.[106]

The other two cases also involved the Alberta Government. It was with this province that federal authorities had experienced the "greatest difficulty" in making arrangements for the transfer of insane convicts to mental hospitals. It had taken in one convict in 1932 and another four in 1936, but it refused to accept "a large proportion" of those convicts who were sentenced in the Province of Alberta. Generally satisfactory arrangements existed with the other provinces during the 1930s.[107] At issue in these two cases was the use by the federal Government of Section 53 of the Penitentiary Act. This clause stated that if a prisoner was found to be insane or imbecile at any time within the first three months of his confinement, as certified by the penitentiary surgeon or otherwise, that he could then be returned to the prison or jail from which he came.[108]

In the first of these latter cases a violent and abusive prisoner was declared insane little over a month after his reception into the Saskatchewan Penitentiary in 1936. Again the province refused to accept the convict into its care, stating the same reasons as it had in the first case discussed here.[109] The other case involved a mentally retarded convict who had been convicted of murder in 1928. Before his trial he had been sent to an asylum in Alberta, where four doctors pronounced him sane. At his trial a defence of insanity was pleaded, but it had been rejected.[110] His sentence of death was commuted to life imprisonment, and soon after his reception at the Saskatchewan Penitentiary he was found by the penitentiary medical officer to be insane. The result was a spate of correspondence between the Department of Justice and the Attorney General's Department of Alberta. The provincial authorities refused the transfer for two reasons. The first was the argument that it was not proper for the penitentiary medical officer to decide under the provisions of Section 53 of the Penitentiary Act that a prisoner was insane. The second reason given was that

there were no facilities in the province for the "class known as the Criminally Insane." Subsequently, the superintendent of one of the provincial mental hospitals in Saskatchewan examined the convict and found him insane. His report noted that the prisoner had a mental age of six, and was in no way responsible for his actions. The Alberta authorities were sent this report, but they still refused to accept the transfer of the convict. The Minister of Justice then ordered his removal to the Alberta jail from which he came. However, the authorities there would not accept him. After waiting around for twenty-four hours the prisoner's escort left him on the steps of the jail. The convict then walked away into the local village until he was arrested by the local police for being unlawfully at large. For the next eighteen months this unfortunate man remained in jail, the subject of a heated correspondence between the provincial and federal authorities, until the Department of Justice decided to end the matter by accepting the prisoner back into the Saskatchewan Penitentiary.[111]

The strained relations evident here may have related to the generally poor relationship between the two levels of government. In the late 1930s the narrowly centrist Liberal federal government was at odds with the Social Credit government of Alberta. The latter's legislation to license and tax federally-chartered banks, to issue "social dividends," and to muffle the press was either disallowed by the federal Government or ruled unconstitutional by the judiciary.[112]

Whatever the relationship of these three cases to a larger dispute, their citation by the Commissioners clearly pointed out the resistance of the provinces to being charged with the care and treatment of insane prisoners. The provinces argued that the provisions of Section 53 where ultra vires of the powers of the federal government. The penitentiary medical officer alone had the power to declare a prisoner insane upon his reception, thus making his maintenance a provincial responsiblity. Moreover, the provinces argued that when a jury refused to find the prisoner "not guilty on the ground of insanity" the

penitentiary doctor should not be able to certify him insane, unless his mental condition had changed between the time of his trial and his admission to the penitentiary. Also at issue was the time-worn complaint that mental institutions were not suitable for the treatment of dangerous criminals guilty of grave crimes, with their presence unfair to the "law abiding citizens" there. The Commissioners examined these arguments and rejected all but part of one of them. They considered that the cost of the maintenance of any insane prisoner ought to be borne by the federal government, even though he was certified to be insane at the time of his reception into the penitentiary. While Section 53 was not regarded as ultra vires, it was nonetheless held that the judgement of "a court of competent jurisdiction" should be respected.[113] The Commissioners generally saw the insane prisoners as mad rather than bad. They could, therefore, not be viewed as "criminally insane" and accordingly a federal responsibility.

> Those who have committed, or are likely to commit, violent or unlawful acts by reason of their insanity are essentially a medical problem and not a legal one. They are, in no sense, criminals, because their violent tendencies are due to mental disease. As diseased persons they are necessarily a responsibility of the province.[114]

The Department of Justice thus continued to rely on the provinces for the treatment and care of insane convicts, although it was a solution which relied on the goodwill of the latter to accept this responsibility. However, in the case of Alberta the absence of such cooperation had created an extremely difficult situation. Otherwise during the period between the two World Wars this pragmatic policy worked out reasonably well. Nonetheless this class of convicts would continue to pose problems for penitentiary officials. The next decade witnessed the inception of psychiatric services in the Canadian penitentiary system, a development spurred on by further problems in transferring insane convicts to provincial mental hospitals.

Although penitentiary medical services in this era were certainly inadequate in many areas, the scope of these services did expand significantly with the formal introduction of dental care in 1922.[115] Some dental care at public expense had been taking place since at least 1918.[116] Now at each penitentiary a properly equipped dental surgery was provided. Dental treatment was extended to cover defective teeth, instead of the previous practice where penitentiary physicians evidently only treated dental problems by extraction.[117] This change in practice made by the Superintendent of Penitentiaries was prompted by reports from the various institutions that convicts were in need of dental care if their health was to be maintained.[118] Nonetheless only work which was regarded as essential was to be done at public expense.[119] Another factor in this decision may have been pressure from the dental profession, such as the College of Surgeon Dentists of the Province of Quebec who in January 1923 unsucessfully petitioned the Minister of Justice to inaugurate a regular dental service at the St. Vincent de Paul pentientiary.[120] While this level of dental care was certainly somewhat limited, it was nonetheless a progressive development. By comparison, in 1927 a survey of American prison hospitals revealed that less than half provided any dental care.[121]

In the early years of this new practice a minority of convicts seem to have benefitted. In 1923 an average of three to four cases per week were treated at the Kingston Penitentiary and at the St. Vincent de Paul Penitentiary, which had convict populations of 729 and 625 respectively.[122] These convicts first had to pass the scrutiny of the penitentiary physican before the dentist would see them on his next visit, which was not on a regular basis but according to the demand for his services.[123] Provision was also made for providing convicts with tooth cleanser. At the convention of penitentiary wardens in 1924, it was decided that the storekeeper at each institution would supply each prisoner with camphorated chalk, to be mixed with a little salt before using it. This practice had

originated some years earlier at the Kingston Penitentiary. At first boracic acid was used as a dental wash, but the penitentiary physician regarded this as too expensive. Instead, camphorated chalk was used. It was a cheap means of protection, costing about fifteen or twenty dollars for the roughly 150 pounds of it used annually.[124]

Until 1932 the onus of paying for dental treatment was primarily on the convict. But if the convict did not have any funds in trust at the institution or friends who would pay, then the government would bear the cost, subject to the approval of the Superintendent of Penitentiaries.[125] Starting In January 1923 the penitentiary surgeon had to provide a certificate for the Superintendent, stating clearly that the recommended dental work was necessary in order to prevent suffering by the convict and to ensure that his health would not be impaired during his sentence.[126] This measure of control was expanded on in September 1924, when the penitentiary medical officer was ordered to report if the inmate could not pay for the treatment and also detail any past work done at the expense of the institution. In addition, the certificate now had to state the probability of any work of the same kind being done in the future.[127] Local dentists chosen by the penitentiary wardens were employed to do this work, provided they supplied their own dental materials. This arrangement was preferred then because it was found more satisfactory than having the institutions supply these materials.[128]

Despite the care taken to minimize the cost of dental care for convicts which was paid for by the Department of Justice, it nonetheless eventually got out of hand. In the fiscal year 1925-26 $3,111 was spent. Three years later this cost had risen to $3,150, but by 1930 it had more than tripled to $10,500. But with the onset of the Depression years of the 1930s this sudden jump in cost could not be tolerated, particularly since all government appropriations were being substantially reduced. Accordingly, in 1931 the dentists and physicians at

several penitentiaries were urged to cut expenditures as much as possible. The medical officer was urged, in the interest of cost-cutting, to protect the government "from being imposed on in this matter," by only certifying what dental work he thought necessary.[129] Another means of reducing expenditure on dental care which was taken in 1932 by Superintendent of Penitentiaries D.M. Ormond was to issue a circular letter to all wardens. Together with a fee schedule this directive on dental care was included in the new Penitentiary Rules and Regulations issued in 1933. The convict was to be provided with "a good biting and grinding surface capable of masticating the ordinary prison ration." Moreover, the new order made it clear that "a good grinding surface" on one side of the mouth only was sufficient for mastication.[130] Apparently this standard for dental care was based on that used by the Canadian militia.[131] As well gold fillings, crowns, bridges, and any expensive appliances were not to be supplied at public expense. Convicts who wished to have dental treatment beyond that recommended by the penitentiary physician could do so at their own expense, provided that the warden gave his approval.[132]

The appointment of part-time dentists at the Kingston Penitentiary and at the St. Vincent de Paul Penitentiary was another effective cost-cutting measure. This change took effect on January 15, 1935. It was made on a trial basis at first to see if economies in the cost of dental treatment could be obtained.[133] While large expenditures had to be made initially for equipment and supplies, the change did prove to be successful. In the fiscal year 1935-36 $2,000 was saved at the Kingston Penitentiary.[134] Unsatisfactory past experience may have contributed to this change in the employment of dentists. After the October 1932 riot at the Kington Penitentiary was quelled the subsequent investigation by Superintendent Ormond which examined the grievances of convicts heard many complaints about dental treatment. It became clear that the dentist was "not carrying out his duties in the best interest of the [Penitentiary] Service."

Some of his work was below the standard he was capable of, and he was levying very excessive charges for work done at the convict's expense.[135] Dr. O.C.J. Withrow described this system of extortion in his memoir about life at the penitentiary.

> There is a dentist who visits two mornings each week. He is not paid a salary but secures pickings from the inmates and the Government and charges all that the traffic will stand...The system pursued is most unfair and most unsatisfactory. If an inmate wishes to see the dentist he must parade before the prison physician who does not examine his mouth but invariably marked [sic] his request favourably. The man may be called to see the dentist in a week, or a month or not at all. But when a list is made out for men to parade to the dentist it is sent first to the North Gate so that the balance standing to the credit of the man's trust fund may be marked opposite his name. Then the dentist sees the man. If he has money the charge is graduated to the size of the balance. If the man has no money the dentist sizes up his mouth, makes out a report as to the amount of work required and the warden then says whether it shall be done at Government's expense or not at all. A very small percentage get work done in this way and only when an inmate is a 'rat' or has influential friends or relatives outside.[136]

These complaints seem to have had some effect. Two weeks after the riot the quality of the dentist's work improved markedly. Nevertheless the convicts complained without success about the tooth powder supplied, preferring instead to be issued with tooth paste.[137]

It had been the plan to establish dental laboratories at the Kingston Penitentiary and at the St. Vincent de Paul Penitentiary, following the appointment of part-time dental officers to these institutions. However, there were problems at the latter penitentiary regarding the manufacture of dentures. It did not have a convict mechanic and four years was required to train one. A commercial laboratory continued, therefore, to supply dentures. No problems existed in this respect at the Kingston Penitentiary. A dental clinic producing very satisfactory work was quickly set up in the North-west cell block or old female prison. Two convicts were trained and supervised in this work by the part-time dentist, with another two added there by the end of the first year of

operation.[138] As a result, by the end of 1937 the use of outside dental services at this institution had been reduced to "an almost negligible amount."[139] However, for all the savings made some were lost because of the stifling bureaucracy which characterized the penitentiary system under Superintendent Ormond between 1932-38. In its report the Archambault Royal Commission pointed to the overly large amount of correspondence over dental services, as was the case with medical services, at the Kingston and St. Vincent de Paul Penitentiaries.[140]

Yet whatever the bureaucratic difficulties that penitentiary dentists had to face, their work was important and pioneering. A great many of the convicts required dental care at the time of their reception into the penitentiary. In November 1936 Dr. R.P. Millan, the dental surgeon to the Kingston Penitentiary, reported to the Warden that of the 270 convicts he had been able to examine on reception over the previous six months, 89% were found to require dental treatment. Most of the middle aged convicts had never had dental care, and their teeth were in such bad condition that they required extraction and the supplying of dentures.[141] Dr. Millan was very proud of the progressive work being done there.

> I do not know of any institution on this Continent or elsewhere that provides such a complete dental service for its inmates as we do at Kingston Penitentiary. This opinion is arrived at by questioning convicts who have dental work done in institutions both in the United States and Canada, and I am given to understand that in American institutions, with the exception of extractions and minor fillings, a convict has to pay for his dental work. Whereas, at this institution a convict is examined and given treatment within thirty days after he is admitted; all fillings and extractions attended to and is supplied with dentures where necessary. All this without cost to the convict and at a minimum cost to the institution. It is worth while [sic] to note, as recorded in our report of the 9th inst., that the 4139 operations performed during the past nine months involved only a material cost of $446.36 - approximately .11¢ per operation.[142]

While dental treatment in Canadian penitentiaries in the 1920s and 1930s evidently varied in quality from one institution to another, its limited introduction does represent a significant advance in the scope of medical services extended to convicts. In addition, the rules and regulations which evolved at this time set the standard for penitentiary dentistry for many years. Even in the 1960s the regulation still prevailed that inmates only be provided with a "good biting and grinding surface" sufficient for eating the prison dietary.[143] Not until the mid-1970s would a more comprehensive approach to dental treatment be adopted in the Canadian penitentiary system.[144]

As in previous eras, the nature of penitentiary medical services in the period between the two World Wars was a good reflection of both the contemporary health problems of the time and of the basic character of the Canadian penitentiary system. The regimen of the latter was becoming less rigid, but it still retained some of its nineteenth century qualities. Isolated from public view, the provision of medical services continued to be, at some institutions, of a substandard and scandalous level. Nonetheless the evidence indicates that this situation was beginning to change by the mid-1930s, as the need for changes here became increasingly evident to both penitentiary officials and to the Canadian public. For example, dental services at the Kingston Penitentiary certainly improved greatly over this period. But the Archambault Royal Commission pointed out in its 1938 report that much reform was needed in the provision of medical services, as was the case with a great many other aspects of the Canadian penitentiary system. And now, in contrast to the changes proposed by the Royal Commission which had looked at the penitentiary system in 1914, there was much more pressure for these major changes. The oubreak in 1939 of another global conflict would delay these reforms but not stop them.

Introduction

The outbreak of the second World War generally delayed action on the recommendations made in the report of the Archambault Royal Commission in 1938. The war effort took priority until the hostilities had ended, to the dismay of those who had campaigned throughout the 1930s for penal reform.[1] Nonetheless some small reforms were carried out in the meantime. These included reducing restrictions on the granting of remission, increased shaving and bathing for inamtes, freer writing and visiting privileges for well-conducted inmates, and a host of minor administrative changes which gave each warden more control over his institution.[2] The gradual realization of full-scale changes started in 1947 with the reorganization of the Penitentiaries Branch of the Department of Justice. In that year General R.B. Gibson was appointed the new Commissioner of Penitentiaries. The previous organizational structure was abolished by the new Penitentiary Act of 1939; the Dominion government, however, had delayed proclaiming this bill until 1947.[3]

Prior to taking office Commissioner Gibson had been charged in April 1946 with considering the recommendations of the Archambault Royal Commission, apart from the questions of remission and the use of clemency. His subsequent report in February 1947 focussed on the implementation of penal reform through the re-organization of the penitentiary headquarters administration, the need for better selection and training of staff, the development of "more scientific" methods of classification, and the need for more accomodation if the segregation of the different classes of prisoners was to be facilitated. These steps, supported by the wardens and the senior officers of the Penitentiary Service, were "essential preliminaries in the adoption of a broad policy that will place greater emphasis on the corrective and rehabilitative aspects of institutional treatment."[4] Among the reforms put in place within the next few years were a system of classification, partial segregation, vocational training for inmates

able to learn trades, and the establishment of a staff training college.[5]

As part of the re-organization of the Penitentiaries Branch headquarters two Deputy Commissioners were appointed. One was in charge of the educational, recreational, and rehabilitative facilities in the institutions. The other was responsible for the supervision and development of medical and psychiatric services, in addition to the development of research and statistics for assessing the validity of present and proposed methods of correctional treatment.[6] The appointment of a chief of penitentiary medical services was of course not a new idea. It had been called for several times before, in 1915, 1921, and in 1933. The first holder of this post was L.P. Gendreau, a Manitoba psychiatrist who during the second World War served with the Royal Canadian Army Medical Corps as adviser in psychiatry.[7] He remained at this job until his retirement from the Canadian Penitentiary Service in 1970.

This new era in the administration of Canadian penitentiaries was heralded with great optimism by penitentiary authorities. Now the reformation of the prisoner by individual and humane treatment was the philosophy behind the new program of penal reform. The new approach followed the direction taken in the report of the Archambault Royal Commission, which emphasized that the fundamental basis of a good penal system was the protection of society. This aim was not to be achieved simply by the temporary incarceration of the offender, but by the "transformation of reformable criminals into law-abiding citizens and the protection of those who are accidental or occasional criminals from becoming habitual offenders."[8] The old era of penology was clearly broken away from, denigrated as a time where the prisoner was released into society "with a twisted and warped personality brought upon through the brutality of prison officials."[9] A new age of corrections was now at hand, paralleling similar developments concurrently taking place in the United States.[10] The emphasis on the reform and rehabilitation of the prisoner now centered on the individual, instead of on the

repressive mechanisms of fortress-like institutions governed by custodialism. Nonetheless a military-style prison regimen was still the rule, punctuated at each institution by the frequent ringing of a bell to signal the daily activities and movements of prisoners.[11] And not until the 1960s would prisoners no longer have to wear identifying numbers on their clothing.[12]

Moveover, for all the rhetoric of the new penology being applied to Canadian penitentiaries the antiquated physical plants of these institutions had to remain fully in use during the 1940s and 1950s. Roger Caron, author of the best seller Go Boy!, was an inmate at the Kingston Penitentiary in the late 1950s. In his memoir of prison life he described how the place was infested with predatory sewer rats and how the cell blocks were poorly ventilated.[13] The 1950s was also not free of riots and disturbances.[14] The worst episode came in August 1954 when a serious fire set by rioting inmates at the Kingston Penitentiary destroyed a number of workshops and irreparably damaged the dome of the institution.[15] Nor was the introduction of a new breed of criminologists into the penitentiary culture a smooth process. Psychologists experienced difficulty in adjusting to the discipline and routine of these institutions. Problems occurred because they entered the penitentiary system without any correctional experience but with great optimism that all the problems they encountered could be solved. For example, some of the psychologists tried to tell other staff members how to manage inmates. Such comments were not always well received and caused resistance to their work. It took years for these correctional pioneers to be fully accepted by other penitentiary staff.[16]

Although the antiquated physical plants of Canadian penitentiaries continued to remain in use, gaunt reminders of a former era of corrections, the life of the inmate did change during the 1950s. Emphasis was increasingly being placed on work and socialization. At the Canadian Congress of Corrections in 1957

Allen J. Macleod, the Director of the Remission Service of the Department of Justice, proudly looked back at the ten years since the appointment of Commissioner Gibson.

> Inmates' sport committees are now to be found in each institution. Baseball, football, hockey and other games are played by inmates not only between themselves but, in most institutions, with teams from outside. Hobby work is permitted in the cells when the prison is closed. At the present time almost half of the total penitentiary population engages in hobbycraft or similar recreational activity during cell time. The Alchoholics Anonymous programme has been instituted in all institutions and is operating successfully. Free correspondence courses are available to inmates. The Dale Carnegie Course is carried on at three of the institutions. In all the penitentiaries inmates are permitted to publish monthly magazines. All inmates are permitted to subscribe to daily newspapers, none of which are censored. A graded scale of prisoner remuneration has been introduced and the amount of remuneration has been increased. Small canteens are operated to enable inmates to secure small creature comforts out of their daily remuneration. It may seem to many to be a small thing, but prisoners are now permitted to shave themselves and are issued with safety razors and blades for the purpose. Small thing or not, there is no doubt that this privilege is calculated to promote a feeling of self-respect and dignity on the part of an inmate. At five of the institutions a vocational training program is carried on at which are taught the trades of brick masonry, cabinet making, automotive mechanics, barbering, carpentry, commercial drafting, electricity, machine shop, plastering, plumbing, sheet metal working, upholstering and welding. The result obtained thus far from vocational training in the penitentiary have been satisfying indeed. The penitentiary authorities say that their graduates are able to find work much more easily than was formerly the case and that more than eighty percent of those who have taken the training have not reverted to crime.[17]

The 1950s was a decade of gradual penal change, in contrast to the 1960s when the size and structure of the Canadian penitentiary system was radically altered. This process started in earnest in September 1960 with the appointment of Allen J. MacLeod as the new Commissioner of Penitentiaries, succeeding R.B. Gibson. In 1959 MacLeod had been assigned, together with Col. James Stone and James A. McLaughlin, to study the Canadian penitentiary system. The report of their group, the Correctional Planning Committee, was handed down in the summer

of 1960 and it became the guide for major reforms. Specialized institutions to meet the needs of the different kinds of offenders became the norm. Expansion of the penitentiary system was also needed to relieve serious overcrowding. Consequently the number of institutions grew dramatically, from eight in 1958 to about forty in 1970.[18] By 1962 a period of growth unrivalled since the first two decades after Confederation in 1867 had created a system of fifteen minimum, four medium, and seven maximum security institutions. It had only been only three years earlier that the first minimum and medium security institutions were opened, at William Head, British Columbia and at Joyceville, Ontario, respectively. Further expanison came with the initiation in 1963 of a "Ten Year Plan" for penitentiary construction. Ten new institutions of differing sizes and security levels were built. At the same time four temporary minimum security institutions were phased out. And in the interest of better administering the expanded system the Canadian Penitentiary Service was decentralized through the creation of regional headquarters across the country.[19]

The 1960s was also the hey-day of the treatment ideology in Canadian penitentiaries. Small institutions was the standard and the Commissioner of Penitentiaries obtained from the Government assurance that the new institutions under construction would not exceed 450 inmates in size.[20] It was also intended shut down the old and outmoded institutions. However, to date the only one permanently closed has been the British Columbia Penitentiary, which finally shut its doors in 1980 after just over a century of operation.[21] A closer link to the community was forged with the inception in 1961 of "temporary absence" passes for the purpose of providing compassionate and rehabilitative leaves of absence.[22] More psychologists and social workers were hired to assist in classification work, although difficulties were experienced in filling these positions.[23] Added emphasis was placed on staff training as the number of staff colleges was increased. Other opportunities for career advancement came as transfers to other

institutions across the country became possible and more senior positions were created in the institutions.[24]

A number of reforms were initiated in this decade. Inmates could now receive apprenticeship training for a number of trades, more visiting priviledges, the right to books, and increased correspondence. Corporal punishment, although increasingly falling into disuse, still remained as a disciplinary action.[25] It was not abolished from the Criminal Code until 1972.[26] Another development was the controversial introduction of two super-maximum security penitentiaries, with the opening of the Archambault Institution in 1968 and then the Millhaven Institution one year later.[27] Liberalization was thus mixed with a measure of specialized control over troublesome inmates. It was also a quiet decade, with no serious disturbances between 1963 and 1970, in contrast to the turmoil to follow in the 1970s.[28]

Medical Services

It appears that the poor quality of medical services pointed to at some penitentiaries by the Archambault Royal Commission in its 1938 report was quickly remedied. A direct result of the Archambault report was an investigation in 1942 by the Department of Pensions and National Health into the medical and health care services at the seven penitentiaries across the country. These services were judged to be satisfactory. No serious criticisms were made of the hospital and nursing facilities, nor of the quality of penitentiary physicians and the quality of dental services. The health of the convicts was also noted to be generally good. Several suggestions were made regarding improvements, such as in the storage and replacement of drugs, the routine examination of personnel, and the filling of nursing staff vacancies by graduate male nurses. The war, however, limited the degree to which these improvements could be carried out.[29]

Another wartime change relating to medical services in Canadian penitentiaries was the introduction in 1943 of voluntary blood donor clinics.

Under the aegis of the Canadian Red Cross Society mobile clinics started visiting the institutions regularly to take donations from both staff and inmates.[30] This practice was continued throughout the 1950s and 1960s, and proved to be popular among the penitentiary population.[31] At the Dorchester Penitentiary, for example, an inmate who had received massive life-saving blood transfusions always eagerly canvassed the insitution for donors.[32] The male inmates looked forward to the visits of these clinics, for they much appreciated the presence of female nurses--in contrast to the male penitentiary nursing staff.[33]

Although there was now a chief of medical services for the Canadian penitentiary system, in the era between 1938 and 1970 the provision of medical and health care services in federal penitentiaries continued to be characterized by a large degree of institutional autonomy.[34] The chief line of authority for the penitentiary physician coninued to be to his warden. He was responsible to him for the "medical, surgical, psychiatric and dental care of the inmates and for the hygiene and sanitary conditions of the institution."[35] However, until 1961 permission for all expenditures for outside specialists or laboratory work required the approval of the office of the Commissioner of Penitentiaries. The only exceptions to this rule were for eye examinations and eye glasses. In 1961 a Civil Service Commission study of penitentiary headquarters administrative practices was very critical of the tremendous amount of paperwork involved here. It was a cumbersome practice which produced a duplication of records, at the institutions and at the penitentiary headquarters office. In one particular year these requests had amounted to several thousand in number, with 350 alone coming from one institution. The situation was remedied that same year by a directive of the Commissioner which gave the institutional head the authority to grant these requests, except for elective procedures such as cosmetic surgery.[36] This change probably reflects the growing use of specialists and the increasing penitentiary population.[37]

Interestingly, during this period the daily institutional routine of health care still bore a strong resemblance to the pre-Confederation days of the Kingston Penitentiary. At most institutions the sick parade was held early in the morning, when an inmate could receive treatment for minor ailments or obtain medicines already prescribed by the physician. At this time he could request to see the physician later in the morning. And the hospital officer, like his nineteenth century predecessor the hospital keeper, acted to decide if inmates were too ill to proceed to work.[38] The sick parade also served as a barometer of the general mood of the inmates. When tensions in an institution rose, more would report sick and complain of non-specific ailments.[39] At the Dorchester Penitentiary one of its wardens always closely watched this sign, by checking daily with the senior hospital officer.[40] The official explanation for this malingering, which could make the sick parade rise from one-tenth to one-third of the prison population, was to attribute it to "the emotional component of ill health, resulting from or aggravated by the continual state of frustration associated with incarceration." The services of psychiatrists and psychologists were used to deal with this situation.[41]

The role of the physician also changed somewhat in respect to the examination of prisoners for classification purposes. Starting in 1948 at the Kingston Penitentiary a report of the physical examination given to each inmate on admission was sent to the Classification Department of the institution.[42] The establishment of multi-level security institutions in the 1960s meant further work for penitentiary physicians. Inmates sent to satellite institutions, such as farm camps, had to be certified as free of illness, not in need of surgical treatment, properly fitted with eyeglasses, and any minor prosthetic appliance worn had to be in good condition. The dental health of the inmate also had to be well attended to, with any dentures worn in good condition. Local physicians and dentists were employed to attend to these inmates.[43] Another change was the

effort, starting in the 1960s, by penitentiary headquarters in Ottawa to make the medical officer less of a visiting physician and more a part of the treatment team. This was done through including him in the weekly staff meetings which were initiated in this decade. These meetings took place at both the headquarters and institutional levels."43a

Besides serving to monitor penitentiary medical expenditures Dr. Gendreau had a number of other tasks. He visited the institutions, lectured penitentiary staff on psychiatry, advised the Commissioner of Penitentiaries on medical matters, prepared budgets, and consulted with other provincial and federal officials on such topic as a coordinated national policy for the treatment of narcotic addicts. Apart from his own secretary, he did not have any other staff.

Medical research in penitentiaries was one important area in which Deputy Commissioner Gendreau was involved. He provided advice to the Commissioner of Penitentiaries regarding requests to conduct such studies in Canadian penitentiaries. This was a new practice for the federal penitentiary system, although such experiments had been taking place at American prisons since the 1910s.44 These projects were sanctioned if they were seen as not unduly interfering with the routine of the institution involved.45 An early inquiry in 1950 aimed at studying the psychopathology and neuropathology of inmates. This was done at the Collin's Bay Penitentiary and at the Prison for Women in Kingston, through the use of voluntary psychiatric interviews and electroencephalographic testing.46 One study which was done at the St. Vincent de Paul Penitentiary in 1957 used the voluntary blood donations of inmates for the purpose of clinical study of these samples.47 Another study at the Prison for Women in 1961 tested lysergic acid diethylamide or l.s.d. It was tried out on fifteen psychiatric patients. This hallucinogen was then being widely tested, as it was claimed to be effective in the treatment of schizophrenia and other psychiatric illnesses. Only later in the 1960s would its use come under a heavy

and successful attack.[48] The testing of a drug compound was the subject of one study at the Collin's Bay Penitentiary in 1966. There a group of volunteer inmates received cigarettes, soft drinks, and sandwiches for being guinea pigs in the testing of how much pain was caused by the intramuscular injection of the drug.[49]

Strict ethical quidelines for medical and psychological research in Canadian penitentiaries were issued in 1963 by Dr. Gendreau, on behalf of the Commissioner of Penitentiaries. These guidelines were drawn up because of past requests and the belief that requests for permission to carry out such work would grow in the future, particularly from universities and pharmaceutical companies. At this time most of these requests where made because the Food and Drug Divison of the federal Department of National Health and Welfare would not allow the use of any new drug in Canada, "no matter how reputable the manufacturer, without the production of experimental evidence adduced from rigidly controlled studies on new drugs, based on proven scientific methods." This safeguard, even if the drug was approved for use in other countries, was in place to prevent a recurrence of the thalidomide episode.[50] This mild sedative was first intoduced in West Germany in 1957. It was withdrawn from the marketplace in the early 1960s after its use by pregnant women was found to cause congenital limb deformities in their children.[51]

Another development during this era was the new emphasis placed on the value of medical treatment as an aid to the rehabilitation of the prisoner, through the provision of medical, dental, and psychiatric care which would aid in curbing his "anti-social behaviour." No longer was the prisoner immoral; instead, in the scientific age of the mid-twentieth century he was sick. For example, in the annual Canadian Penitentiary Service report for the fiscal year 1960-61 the report of the Medical Services Division stressed the importance of proper health care.

> Diagnostic and treatment facilities within the institutions, supplemented by those of nearby large hospital centres, have provided the inmate population with all the care which was felt necessary for the prevention of illness, for the maintenance of health and for the eradication of illness. Medical corrective measures were undertaken, where indicated, for rehabilitative purposes...In keeping with the belief that good mental and physical health is essential to the rehabilitation and normal adjustment of the offender to society, inmates who suffer from nervous and mental symptoms have been referred to the Penitentiary Psychiatrist for treatment purposes. At the same time, any inmate who desired to have interviews with the Psychiatrist in order to get assistance in resolving any of his mental conflicts or deviant behaviour, or understanding something regarding his motivation, was able to do so.[52]

Psychiatry, which was introduced in a limited fashion in this era, was important because it was believed that the emotional disturbances many inmates suffered from had played a key part in their criminal behaviour. It was considered, therefore, that unless psychiatric or other means of treatment were utilized the inmate would not function normally in society once he was released.[53] Corrective surgery for physical defects, first initiated in the mid-1930s, was another important medical tool, comprising treatment for such problems as hernias, old tendon injuries, torn knee cartilages, and hemorrhoids. This measure was seen as beneficial to rehabilitation because the interest taken in the physical welfare of the inmate was appreciated by him, thus contributing significantly to his welfare.[54] It was also regarded that physical defects were closely related to the prisoner's criminality.[55] The physician, too, had a part to play. W. Amodeo was the physician at the Kingston Penitentiary from 1954 to 1980. He wrote in 1964 that if this officer, by his example, could be "a good image" to the inmate, then "he may well be responsible for a change in attitude in that inmate which would start him on the way to rehabilitation and a sincere effort to fit into the society around him."[56]

But for all the optimism about the importance of good mental and physical health as an aid to the rehabilitation of the inmate, what did not change for penitentiary health care staff was the hidden conflict of being both a healer and

a disciplinarian. On his retirement in 1980 Dr. Amodeo recounted how it was difficult to alternate between the penitentiary and his general practice in Kingston. After a number of years at the former he developed a hard attitude towards convicts lest they were malingerers, an attitutde which sometimes carried over into his general practice. On occasion these latter patients felt that they had difficulty in convincing him that they were truly ill.[57] Moreover, to work in a penitentiary environment carries with it a significant level of risk to oneself and to co-workers. Unfortunately, since the 1960s an increasing number of correctional officers have been wounded, murdered, or involved in a hostage-taking incident.[58] For one hospital officer, the murder of a fellow officer was a bitter shock which made him almost uncontrollably angry.

> One indian summer evening in September 1964 I was doing some painting at one of the local churches, when an urgent call came for me to report to the Pen. Hospital immediately. When I arrived there a 49 year old guard was laying [sic] on a stretcher in the Health Care Centre. This man had two stab wounds, one into the heart from the front and one into the lung in the back. Within a few minutes our physician Dr. W. Hirtle arrived from Sackville, but all efforts to revive him were in vain...At that time I experienced a sudden rage bringing myself close to the point of seeking vengeance...Why should something like this happen but it did...Here was a fellow employee and a friend, who met a violent death at the hands of a deranged teen-ager, striving for [the] respect of his peers, with a dagger through a man's heart.[59]

While the job of penitentiary health care staff was certainly never an easy one, the tasks they had to face during this era were, in some respects, not as onerous as those of their predecessors. With the addition of psychiatric services more attention could be given to the needs of mentally ill inmates. Tuberculosis and venereal disease ceased to be major problems by the mid-1950s, thanks to major advances in detection and treatment techniques. The problem of narcotic addicts in penitentiaries now received special attention from correctional officials, and the result was the establishment of a separate, albeit short-lived, facility for their treatment.

Psychiatry was of course the most important new aspect of penitentiary medical services. Although the Archambault Royal Commission had pointed in its

1938 report to the serious problems inherent in the practice of transferring mentally ill inmates to the care and treatment of provincial authorities, its Commissioners had generally found the practice to be the best option available.[60] Penitentiary officials, too, were content during the 1940s and 1950s to continue this practice. With only about forty to fifty of these inmates confined in provincial institutions each year the number was not large enough to justify building a federal mental hospital and providing the level of psychiatric treatment required.[61]

Some provincial authorities continued to be reluctant to accept mentally ill inmates from the penitentiaries into their charge, even though official agreements for this purpose were in place in some provinces. The Alberta Government still held in 1947 that this was not a provincial responsibility since the prisoner, obviously sane enough to stand trial, became insane after his admission to the penitentiary. Mental illness was therefore no different than any other form of illness. Another problem was the lack of adequate facilities in mental hospitals for the segregation of these prisoners. In Alberta this want apparently assisted a provincial inmate in murdering a person in the provincial institution where he was confined. Only in Ontario and Quebec were special facilities set aside for this purpose, at the Ontario Hospital in Penetanguishene and at the Bordeaux Provincial Jail near Montreal.[62] But the major problem faced by the Department of Justice was overcrowding in provincial mental hospitals during the 1940s.[63]

It was at the Kingston Penitentiary that this situation reached crisis proportions. The Criminal Insane ward of the Ontario Hospital at Penetanguishene was full throughout the 1940s. Expansion of the facility had not been possible during the wartime years because of restrictions on construction. Nor was room able to be made at the time for new federal patients as none of the present patients could be safely moved to a less secure building.[64] By the fall of 1943 the Deputy Warden of the Kingston Penitentiary feared that the continuing

presence there of seven such inmates would almost surely lead to a very serious incident. One of this group had been certified as insane, and three more would be later. Also, four of these inmates were dangerous or had a disruptive influence on the prison. Until a proper facility for their care and treatment could be found they were mostly housed in the former Prison of Isolation or East cell block of the institution.[65]

The dangers posed by this situation were quickly recognized at the Penitentiaries Branch headquarters in Ottawa. Accordingly, it was clear by May 1944 that a mental hospital would have to be established witnin the walls of the institution. The building chosen was the North West cell block, which until 1934 had been the Female Prison.[66] The intention was to use it for the treatment of psychoneurotic and pre-psychotic inmates. Shortages of staff and equipment delayed the opening of a nine bed ward there until August of 1948.[67] Nonetheless an important start towards the proper treatment of these inmates had been made in 1945 with the hiring of a part-time psychiatrist. The man chosen for the job was Dr. C.M. Crawford. Prior to his appointment he had been Acting Superintendent of the nearby provincial mental institution, the Rockwood Hospital. He brought to the job his belief that most criminals displayed abnormal behaviour, and that psychiatry, psychology, and sociology had a role to play in their rehabilitation.[68] Dr. Crawford retired in 1950 and was succeeded by Dr. Maurice O'Connor who held the post until 1958.[69] In 1958 Dr. George Scott was appointed on a part-time basis at both the Collin's Bay and Kingston penitentiaries.[70] A year later tne Kingston Penitentiary psychiatric ward was relocated--because of increasing demand--to the east cell block of the institution.[71]

In Quebec the overcrowding of the criminally insane ward at the Bordeaux Provincial Jail similarly led to the establishment in 1954 of a psychiatric ward at the St. Vincent de Paul Penitentiary. At the time mentally ill inmates were

confined to the ground floor of the hospital.[72] Dr. Bruno Cormier filled the post of part-time psychiatrist there in October 1955, but it took until 1958 for suitable accomodation to be provided for mentally ill inmates.[73] The new psychiatric centre comprised a unit of eighteen cells, two group therapy rooms, a treatment room and offices for the staff. It was considered by Dr. Cormier in 1959 to be similar but less elaborate than psychiatric facilites elsewhere.[74]

In the 1950s the other penitentiaries also started to benefit from the addition of a part-time psychiatrist to their staff. These psychiatrists attended on a basis of five mornings per week. At the British Columbia Penitentiary and at the Manitoba penitentiary this appointment was made in 1951, and a year later the Saskatchewan Penitentiary received its psychiatrist. Dorchester Penitentiary did not obtain the services of a part-time psychiatrist until 1958.[75] Behind this expansion of psychiatric services in the 1950s was the strong backing of Deputy Commissioner Gendreau.[76] The 1950s was also the first great age of psychiatry. At the start of the decade there were not enough practising psychiatrists to meet the demand. In 1951 only 206 doctors in Canada possessed this qualification, in comparison to 1961 when that number had jumped to 667.[77] Understandably, Dr. Gendreau had difficulty in attracting these professionals to work in the penitentiary system. He made it clear to those interested that the work was going to be difficult, the wages low for the profession, and the guidelines for this practice non-existent.[78] Whatever the difficulties experienced in recruiting penitentiary psychiatrists became an integral part of the correctional process. This fact mirrored their rising prestige in society, of which Robert Fulford has written about.

> In the 1950s most of us knew vaguely what psychiatrists did, but few of us knew one or knew anyone who was actually seeing one. That was all to change with astonishing speed. Psychiatrists began to move from the edges of medicine - and of society in general - toward the centre. As more and more bright young doctors were attracted to the specialty, they discovered more and more patients who needed them. There were

> many explanations for this phenomenon, but perhaps the most obvious one was also the closest to the truth: contemporary life was becoming too fast and stressful for many people. As the American social critic Christopher Lasch summed it up some years later, modern human beings search for "peace of mind, under conditions that increasingly militate against it."[79]

Psychotherapy was the major tool of penitentiary psychiatrists in the treatment of inmates with "emotional disturbances" which were often linked to their criminal behaviour. In this effort these psychiatrists were assisted by other medical staff, and by psychologists and classification officers who provided case histories of inmates which included psychological tests relating to their intelligence, emotional stability, and vocational aptitutdes.[80] In his contemporary study of the British Columbia Penitentiary in the late 1950s Angus Matheson provides a glimpse of the psychiatrist's work.

> Each inmate has an interview with the Psychiatrist at the time of his admission to the Penitentiary. The Psychiatrist then submits a report to the Classification Department giving his evaluation of the inmate. As mentioned previously, some inmates are referred to the Classification Department by the Psychiatrist for psychological testing. Particular attention is paid to young inmates who may be easily influenced, or have a history of sexual deviations. Follow-up interviews are carried out with certain younger inmates selected by the Psychiatrist. He also sees those who present problems in the institution and those who request to see him. A small number of inmates receive individual psychotherapy. Usually between five and ten inmates are under such treatment, being seen at weekly intervals, depending upon the nature of the problem involved.[81]

Understandably, once psychiatric services were introduced at an institution it took a long time for inmates to make ready use of them. This hesitation was due to the fact inmates did not want to get "bugged," believing that the psychiatrist was there to tamper with their minds. This view gradually waned as reluctance gave way to curiosity.[82] By 1958 the benefit of psychiatric services seemed evident as one out of every three inmates was voluntarily seeking psychiatric help, a demand which created a waiting list for most psychiatrists.[83] Psychiatric advice and counselling also took place within the forum of group therapy in several institutions. It was first tried at the Kingston Penitentiary

in 1951, at the request of a group of inmates desirous of making "some readjustment of their lives towards avoiding further imprisonment." The group was limited to an attempt at therapy, rather than as a forum for discussing questions of prison reform, parole, and other similar topics. Its stated purpose was "to discuss basic personality development and to proceed from there to some deeper understanding by the members of the group of themselves in relationship to the basic factors being discussed."[84] This development parallelled events in the United States, where in 1950 over fifty per cent of all state mental hospitals used some form of group therapy. Only five years earlier the use of group therapy by these institutions was in its infancy.[85]

Over the next several years group therapy was initiated at some of the other penitentiaries, with its stated purpose being "to help inmates arrive at a closer understanding of their troubles, resolve some of their conflicts and enable them to use personal resources in developing methods of behaviour acceptable to society."[86] At the Manitoba Penitentiary, for example, there were thirty-nine sessions in the fiscal year 1952-53. On average fifteen inmates attended each meeting.[87] In some institutions the psychiatrist led these sessions, while in others a psychologist in the Classification Department of the prison was charged with this duty but performed it under the direction of the psychiatrist.[88] Besides being popular with the inmates, as evidenced by the formation of three such groups at the British Columbia Penitentiary in 1954, it was also approved of by penitentiary officials because it successfully maxmized the use of the psychiatrist's time. This enabled him to see inmates he would not have otherwise had time for, as individual psychotherapy was time-consuming.[89]

Electro-convulsive therapy was used in a small number of cases each year. Its use, without the inmate's consent, was authorized in 1949 by the Minister of Justice for those cases where the psychiatrist considered it would be beneficial

to the inmate.[90] For example, it was given to twelve patients at the Kingston Penitentiary in the fiscal year 1951-52. Each of them averaged nine and a half treatments.[91] It certainly had a strong effect on one inmate. Roger Caron, author of Go-Boy!, voluntarily elected to receive it. Otherwise he could not remain in the psychiatric ward at Kingston Penitentiary instead of serving almost two years in solitary confinement for an attempted escape from the institution.[92]

> The moment that I dreaded was now at hand; I stared hypnotically at the doctor crooking his finger at me...Briskly the doctor ordered me to lie down on the table and roll up my right sleeve. In a moment two of the nurses were administering to me, one rubbing alcohol in the crook of my arm while the other daubed glue on my temple to hold fast the electrodes for the current...'Start counting backwards from one hundred slowly,' ordered the doctor as he squeezed medication into my blood system. My voice was barely audible by the time I ticked off 'ninety-two.' That was when the switch on the machine was activated! My brain seemed to explode inside my skull as I bit down convulsively on the stick and my body jerked about spasmodically on the table. A few more jerks and I suddenly went limp.[93]

Occupational therapy was also used as a means of treatment at the Kingston Penitentiary. It comprised such activities as cards, checkers, hooked rugs, woodwork, model boats, and shellcraft. Yet the association of mentally ill inmates for this purpose was not without its problems. Special care had to be taken in not providing dangerous inmates with tools which could easily be turned into weapons.[94] Unfortunately, this fear was borne out there in October 1958 when a number of inmates held some penitentiary officers hostage in the toy shop. The incident ended without injury but this form of occupational therapy had to be discontinued.[95]

The activities of psychiatrists were not limited to the treatment of inmates. On occasion they assisted in staff training with lectures on various

aspects of psychiatry. This work was regarded as very important because the staff needed to have an understanding of the inmate personality and of the causes behind criminal behaviour. Also they needed to understand something of themselves. Such training was designed to enable correctional officers to handle themselves better and to cope more effectively under difficult circumstances.[96] Part of the new view of the inmate personality came from the research projects carried on by penitentiary psychiatrists. Among the themes examined were the dangerous sexual offender, the effects of sensory deprivation, the effects of the deprivation of liberty, and the nature of criminality.[97] The most notable of these writings is by George Scott, and it describes his experiences during twenty-six years of work in the penitentiary system. For example, in his book titled Inmate he portrays malingering as a self-interested action motivated by several possibilities.

> Inmates, not actually ill, may develop artificial complaints to obtain drugs which they can use as currency in the prison barter system...Inmates too, may magnify their complaints with a view to "hoarding" their medications against some future date when they may be in short supply, or when problems such as parole turndown, may make reality unacceptable...Prisoners may use the sick parade as a social forum wherein communication is established with other segregated inmates. Complaints have to be presented to justify their presence. The complaint and the prescriptions are of secondary importance. At times, large sick parades are developed to irritate the medical officer because of some misunderstanding. The officer becomes skilled in this double dealing and never loses the respect of the inmate if he sees through their manipulations.[98]

Psychiatry thus became well established as an important part of correctional treatment. The level of services provided were certainly limited, but it was comparable to the number of other medical personnel. On March 31, 1964, for example, there were eleven physicians. One of these was full-time, three were part-time, and the other seven worked on a contract basis. Other health care personnel--dentists, hospital officers, assistant hospital officers, and dental technicians--numbered 111. All in all, these 130 people made up only a small

part of the 2,912 staff members at the various institutions.[99] Penitentiary psychiatric services would not be expanded until the early 1970s, when it became clear to federal correctional officials that a number of changes were sorely overdue.

The efforts of penitentiary psychiatrists were not confined to the treatment of mentally ill or emotionally disturbed inmates. The treatment of drug addicts also occupied their attentions. This was far from being a new problem. In 1901 the Inspector of Penitentiaries Douglas Stewart was severely critical of the surgeon at the St. Vincent de Paul Penitentiary. The latter had dispensed very large quantities of opium and morphine, which, in the opinion of the Inspector, was responsible for the general ill health of the convicts there. Instead, its surgeon had attributed this condition to the poor state of the cooking kettles and tableware at the penitentiary.[100] Narcotic addiction was certainly a growing problem in the late nineteenth and early twentieth centuries, but it was not until the 1920s that the presence of "dope fiends" in Canadian penitentiaries became prominent. Parliament had first passed restrictions on the importation, manufacture, and sale of opium--for non-medicinal purposes--in 1908, in response to the report of a Royal Commission on Chinese opium smuggling. Other related legislation was passed over the next fifteen years. However, this legislation was not strongly enforced and it remained for public pressure--motivated in part by Emily F. Murphy, a crusading police magistrate and juvenile court judge in Edmonton--to bring about more effective legislation and enforcement. As a result, in 1923 Parliament passed the Opium and Narcotic Drug Act.[101] Many addicts were now ending up in Canadian penitentiaries. Most were sent to the British Columbia Penitentiary, since the greatest concentration of addicts was in that province. For example, in the fiscal year 1924-25 this institution received twenty known addicts.[102] In his annual report for 1922-23 the Superintendent of Penitentiaries drew attention to the serious difficulties created by this new problem.

> In one institution almost one-third of those received during the year were slaves to narcotics of one kind or another. Such inmates are a menace to the peace and discipline of an institution. There is no depth to which a confirmed addict will not descend in order to obtain a supply of the drug. Traffickers in "dope" on the outside will make easy money, and spend it lavishly, in attempts to keep their friends in prison supplied. It is very difficult to wean an addict from the habit once formed. They become unreliable, untrustworthy, and often thoroughly depraved. Extraordinary measures should be adopted to stamp out this rapidly increasing menace. Reports at hand show there to be 125 inmates in the penitentiaries who are recognized "drug addicts."[103]

The problem of drug addicts in Canadian penitentiaries was discussed at the 1924 convention of wardens. There the Warden of the British Columbia Penitentiary called for the establishment of a separate institution for the treatment of these persons. He argued that many cases could be cured, before the addict committed a crime, if the provincial authorities would establish a treatment facility to which these persons could be sent. In response Superintendent Hughes advised that this was a provincial rather than a federal matter.[104] Evidently further interest in this problem was lacking until the late 1930s when it was examined by the Archambault Royal Commission. Its report in 1938 noted how troublesome these prisoners were, and strongly emphasized that there was no cure for their addiction. Because the need to support their expensive habits made them into habitual criminals, a separate institution was needed for the indefinite imprisonment of these scarcely reformable offenders. The scattered distribution of population across the country made this aim unfeasible; consequently, the Commissioners thought that many of these prisoners might be removed to a prison for habitual offenders or incorrigibles.[105]

This call for a special institution went unheeded in the 1940s and 1950s. In his review in 1947 of the recommendations of the Archambault Royal Commission the new Commissioner of Penitentiaries General R.B. Gibson stated that the necessary space could not be spared.[106] Nonetheless it was certainly recognized at the time that this was a serious problem deserving close study. In 1947 a

federal Cabinet Order-In-Council established an advisory committee on narcotic drug addiction. It was made up of representatives from the Department of Justice and the Department of National Health and Welfare. In 1948 this committee reiterated the call for a institution for drug addicts which would be maintained by the federal Government. It regarded the existing treatment facilities in mental hospitals, jails, and penitentiaries as inadequate chiefly because these institutions could not provide occupational facilities and treatment suited to the personality of the addict. Other reasons included security problems in mental hospitals, the punitive atmosphere of jails and penitentiaries, and the fact that the number of addicts in any one province was not large. It was clear to the committee that these difficulties made it unlikely any province would set up an institution of this kind for the per capita cost would be too prohibitive.[107]

The federal Government did not act on this recommendation at the time. The only medical treatment an addict might receive was assistance in aiding his withdrawl from the drug or medicine by administering it in diminishing quantities to negate the symptoms produced by this process. In many instances withdrawl had already taken place by the time the inmate was admitted into the penitentiary. Whatever the case, the inmate who was a drug addict became part of the general penitentiary population.[108] It was regarded that there was no medical cure to drug addiction, rather being "a matter of changing the mental habits and attitude of the individuals."[109] To this end psychotherapy was used, but in the 1950s very few drug addicts voluntarily sought it, either individually or in a group setting. Many addicts wanted no part of this treatment. Some believed that only heroin or morphine eased their tensions, while other addicts were too rooted in their habits to desire psychiatric advice.[110]

The call for a separate institution for the treatment of drug addicts was renewed in 1955 by the Fauteaux report on the parole service of the Department of Justice.[111] That same year a special Senate Committee on the traffic in narcotic

drugs in Canada also viewed this facility as necessary, but termed it a provincial responsibility. Deputy Commissioner Gendreau was one of those who had told the committee that such an institution was needed. The committee was concerned about the treatment of drug addicts in penitentiaries, particularly in regard to the fact that they were not segregated from other inmates. It regarded this situation as unsatisfactory because it might serve to tempt others into narcotic addiction.[112] Increasing concern by the public and by correctional officials about the problems caused by narcotic addiction brought the Government to adopt a new policy, and construction of an institution for the treatment of narcotic addicts was approved by the federal Cabinet in early 1960.[113] Part of this change in policy was the passage of the Narcotics Control Act in 1961, which replaced the Opium and Narcotic Drugs Act of 1923.[114] Planning for the new institution started in 1961, and in March 1966 the Matsqui Institution opened at a site some forty miles east of Vancouver. Its location reflected the fact that almost sixty per cent of the approximately 3,800 narcotic addicts in Canada then lived in the Vancouver area, where their criminal activities and the danger of others being enticed into addiction had aroused serious concern.[115]

The new facility had a staff of 339 to run the male unit of 312 inmates and the female unit of 128 inmates. In each unit was a pilot treatment unit where a select group of inmates, separated from the rest of the population, received intensive psychotherapy. The institution provided vocational and industrial training together with the opportunity for academic upgrading. Its objective was "to provide a controlled drug-free environment where the addict can develop personality characteristics that will enable him to live in society without resorting to criminal activity or using narcotics." Like similar American institutions for the treatment of drug addicts, it was not expected to find a "cure" for them. Instead, it was regarded that the only realistic approach was to set limited and reachable goals. These goals were described as helping the

addict to obtain and keep a job--when this had seldom or never been the case--and to help him abstain from drug use for a period of time in the outside community. To help achieve these goals intensive counselling was provided, consisting of group therapy supplemented by, where it was indicated, individual psychotherapy.[116] While the immediate objective of the institution was the welfare and treatment of the inmate, its fundamental goal was the "long-term acquisition and development of knowledge in the field of narcotic addiction."[117]

When this new institution was opened it was felt that the experience gained there might yield some answers about the problem of drug addiction. Its programs were certainly innovative, such as the first after-care programs for addicts. Previously, they were rarely permitted parole. The need for this continuing contact and supervision was seen as essential, and this need had been clearly demonstrated by the experience of similar institutions in the United States.[118] However, the Matsqui Instititution was short-lived as a drug treatment facility. In 1968 it became just another medium security institution. It was closed after just three years of operation because the British Columbia courts were not sentencing enough addicts and traffickers in narcotics to penitentiary terms. The institution could, therefore, not be filled to capacity. Although it was the decision of the Government at that time to close this facility, it was then regretted by the Commissioner of Penitentiaries Allen J. MacLeod. In his view this experiment should have been allowed to operate for at least five to ten years, in order that the need and justification of a specialized program for the treatment of narcotic addicts could have been evaluated.[119] Since that time these inmates have been treated in provincial institutions prior to entering the penitentiary system. However, in 1977 the Sub-Committee on the Penitentiary System in Canada recommended the establishment of a special institution in British Columbia for the treatment of drug addicts.[120] In response, the

Solicitor General pointed out, inter alia, that earlier such treatment programs within penal institutions had proven disappointing.[121]

In contrast to the new emphasis on psychiatry and the treatment of narcotic addiction, this era did see two old medical problems fade away. Both tuberculosis and venereal disease gradually became scarcer in Canadian penitentiaries as new diagnostic and treatment methods cured these cases and eliminated sources of infection.

Of these two problems, tubercular inmates posed the greater problem for penitentiary officials. The policy adopted in the early 1940s of removing active cases, on a temporary ticket-of-leave, to provincial sanitoriums was an expedient response to the scandalous situation exposed by the report of the Archambault Royal Commission in 1938.[122] It was obvious that the kind of treatment required could not be provided within the confines of a penitentiary. Within the space of several years this practice came under attack from the provincial health authorities. The provinces had found themselves inconvenienced by the need to provide special security arrangements for these patients. The issue surfaced at a meeting of the Dominion Council of Health held in Ottawa in May, 1945. It was said at the meeting that the disease was prevalent in Canadian penitentiaries. The meeting went on to resolve that adequate facilities for the treatment of tubercular inmates be provided in these institutions, and that the Penitentiary Act be amended to permit tubercular prisoners to be admitted to penitentiaries.[123] While obviously very similar to the situation of inmates who became insane while in custody and were then, if possible, transferred to provincial mental hospitals, the number involved here was very small. On July 1, 1946, for example, there were only two inmates hospitalized in provincial sanitoriums.[124]

In response to this pressure from provincial authorities the Department of Justice stood its ground. Regarding the care of tubercular convicts it made the same argument as it did the care of insane inmates; namely that health care was

a provincial responsibility under the British North America Act of 1867. It was therefore just as opposed to setting up a penitentiary sanitorium as it was to operating a penitentiary mental hospital.[125] It was noted that had the inmate not been sentenced to imprisonment in a penitentiary, then his treatment probably would have been a charge on the province. Moreover, the number of inmates involved simply did not justify the considerable expenditure for such a facility. In the period 1936-46 only thirty-eight cases of tuberculosis were recorded in Canadian penitentiaries. Twenty-two of these had developed after admission to the institution. Also the average time spent in sanitoriums by these inmates was only 13.2 months. The establishment of a penitentiary sanitorium was thus both uneconomical and a duplication of existing provincial services.[126] Nonetheless this remained a contentious issue during the 1940s and 1950s, and it would sometimes surface when an inmate required treatment at a provincial sanitorium.[127]

Not all inmates with active cases of tuberculosis were transferred to provincial sanitoriums. In exceptional cases this transfer was not possible because of the nature of the inmate's crime.[128] Another factor was the overcrowding of provincial sanitoriums.[129] And in some instances the inmate was a disciplinary problem at the sanitorium and had to be returned to the penitentiary.[130] Understandably, the penitentiary facitlities for the segreation of tubercular patients were improved between 1938 and 1947. At the Saskatchewan Penitentiary the separate range of its hospital was partitioned off by a glass divider. Also part of the range was taken up by a glassed in area exposed to the sun.[131] Provision for isolating tubercular convicts was also made at the Kingston Penitentiary.[132] However, this solution there evidently left much to be desired. On one occasion, in 1947, a Coroner's Inquest was severely critical of the arrangement in the ancient hospital of the penitentiary. It pointed

to the lack of segregation between tubercular and non-tubercular patients. However, the penitentiary medical officer was absolved of any blame.[133]

Fortunately, during the 1950s the control of tuberculosis in penitentiaries was aided by better methods of detection and treatment. By the mid-1950s the number of fatal cases in Canada was declining sharply.[134] Real progress in eradicating this ancient disease had come a decade earlier when the antibiotic drug streptomycin was discovered in 1944. It had a certain curative effect and was soon in widespread use. In many cases its use produced a great improvement in the patient's condition. By the 1960s other antibiotic drugs were added to the armamentarium of the physician, effectively supplementing streptomycin and, importantly, in combination with it preventing the tubercle bacillus from otherwise quickly becoming resistant to the new antibiotic.[135] As a result collapse therapy or artificial pneumothorax and resection surgery--the mainstays of the therapeutic treatment of pulmonary tuberculosis in the period between the two World Wars--rapidly fell into disuse and disrepute by the late 1950s.[136]

The other major aid in the increasingly successful campaign against tuberculosis was mass radiography. Within a year of the discovery of x-rays by Wilhelm Conrad Roentgen in 1895 its use in the diagnosis and management of pulmonary tuberculosis was being considered by British and American physicians.[137] Over the next two decades improvements in technique made x-ray examination a practical method of detecting small areas of inflammation which could not be found on physical examination.[138] By the 1920s this diagnostic tool was being increasingly used by thoracic surgeons, whom it provided with essential information on the state of the lungs before and after treatment. Thus despite staunch opposition from senior physicians convinced of the accuracy of physical examinations, the routine x-ray examination of pulmonary cases of tuberculosis became an accepted medical fact by the 1930s.[139] In Canada mass screening began

as early as 1925, involving at first such groups as university students, medical personnel, and Native Canadians.[140]

The mass screening of all penitentiary inmates and staff was called for by the Dominion Council of Health in May of 1945, at the same meeting in which it recommended the establishment of a federal sanitorium. The former had already been partly acted upon that April, when the 500 officers of the St. Vincent de Paul Penitentiary were x-rayed by personnel from the Department of National Health and Welfare.[141] Over the next few years inmates and staff across the country began to be checked regularly for the disease. The result revealed that it was not prevalent.[142] For example, a mobile clinic visited the Manitoba Penitentiary in November, 1945, and examined seventy-nine officers and 258 inmates. The screening only revealed signs of the disease among five inmates. Fortunately, in only one of these cases was the inmate suffering from tuberculosis and this was a minimally active case.[143] These travelling clinics were sponsored by provincial anti-tuberculosis associations, which were partly supported by federal grants. These clinics helped greatly to detect any cases where the disease was suspected of being in its early stages.[144]

Further protection against tuberculosis came from the fact cases of the disease among inmates were now being detected at some of the larger provincial jails, prior to commitment to the penitentiary.[145] But perhaps more important in the detection of the disease among new inmates was the addition in the early 1950s of x-ray equipment to penitentiary hospitals.[146] This need had been recognized as early as 1931 by officials at the St. Vincent de Paul Pentientiary. However, the cost had long been regarded as prohibitive. Questions had also been raised about the ability of penitentiary physicians to read x-ray films with accuracy.[147] Now inmates could be more readily x-rayed if they displayed signs of tuberculosis. And it was no longer necessary to transport them, with security escorts, to outside hospitals for this purpose.

But the greatest security against the disease came with its gradual elimination from Canadian society by the 1960s. Today doctors in the federal corrections system of course still continue to watch for tuberculosis, but now it poses far less of a menace than in the days before antibiotics and mass radiography.[148]

Like in the case of tuberculosis, the development of an effective antibiotic drug enabled penitentiary physicians to achieve unheralded success in the fright against venereal disease. The discovery of penicillin in 1943 by Sir Alexander Fleming led to cures which were barely short of miraculous. Very soon after penicillin had completely replaced all other therapeutics in the treatment of syphilis at any phase of the disease.[149] Massive injections of penicillin were prescribed for all new cases of syphilis among inmates.[150] The result was impressive indeed; in 1944 syphilis had apparently been on the increase, but by 1948 the number of venereal disease cases was clearly in decline and few new cases were found.[151] Because inmates with venereal disease were now treatable they were no longer excluded from the penitentiaries under Section 46 of the Penitentiary Act, which required sheriffs to provide proof that the inmate being delivered to the penitentiary was free of infectious disease. Instead, by 1951 cases of tuberculosis were more watched for among new prisoners.[152]

Another development in this era was the expansion of penitentiary dental laboratory services. The first change here was the establishment of a laboratory at the St. Vincent de Paul Penitentiary in the early 1940s. In charge of the new facility was an officer who was a qualified dental mechanic. His duties included keeping records of the work done there.[153] This change was evidently prompted by the great economies to be made by not relying on outside dental laboratories. In 1940 the cost of the latter practice, at $4.79 per capita, was almost ten times the cost at the Kingston Penitentiary. At that institution the same cost was only $.50 because of its efficient laboratory.[154] The job of the part-time dentists at these two penitentiaries was made easier by the elimination of the

requirement that dental services for inmates had to be approved in each case by the Superintendent of Penitentiaries.[155] And these services were provided at a very low cost. For example, 585 dentures were made at the St. Vincent de Paul Penitentiary in the fiscal year 1946-47 at an average cost of $1.07 each.[156] This end of this decade saw the replacement of obsolete equipment at the Kingston, St. Vincent de Paul, and Manitoba penitentiaries.[157]

The dental laboratory at the Kingston Penitentiary depended on a number of key inmates who were trained and expert in this work. However, by the end of the 1940s it was operating with difficulty becasue of the removal, illness, or discharge of these persons. It was therefore decided by the Department of Justice to adopt a new plan, and have this work done on a permanent and satisfactory basis at the St. Vincent de Paul Penitentiary.[158] By 1953 this enlarged laboratory was supplying dentures to all the penitentiaries in Eastern Canada and to the British Columbia Penitentiary.[159] This arrangement reflected the fact that part-time salaried dentists were appointed at the Dorchester Penitentiary and at the British Columbia Penitentiary in April, 1952, in addition to the existing positions at Kingston and St. Vincent de Paul.[160] By March of 1956 all the penitentiary dentists were employed on the same basis. In the fiscal year 1955-56 they treated more than 3,000 of the 5,508 inmates in the penitentiary system, with the dental laboratory at St. Vincent de Paul making 1,512 full or partial dentures for the various penitentiaries.[161]

By the end of the 1950s there were signs that the dental laboratory at the St. Vincent de Paul Penitentiary was inadequate to meet the demand for dentures. In 1959 the annual penitentiary service report noted that dentists in Western Canada believed that delivery was a little too slow for their convenience. It was acknowledged that changes might be necessary.[162] By March of 1961 the Department of Justice had decided to establish new dental laboratories at the Kingston, Manitoba, and British Columbia Penitentiaries. These were put into

operation within the next year.[163] The laboratory at the Manitoba Penitentiary also served the Saskatchewan Penitentary, while the St. Vincent de Paul laboratory continued to supply the needs of the Dorchester Penitentary. These were certainly valuable services because in most cases the poor oral hygiene of inmates necessitated extraction.[164] Nonetheless these services continued to be somewhat limited in nature, aimed at "preserving the mouth in a sanitary condition" and the provision of a "good biting and grinding surface" for the inmate.[165]

All in all, the delivery of medical services in the era between 1938 and 1970 was marked by major developments in the areas of medical, psychiatric, and dental care. Particular attention was given to the needs of the mentally ill offender and to those inmates imprisoned for narcotic addiction. Yet there were some problems which would only be tackled by the next generation of correctional officials. One area of concern was the use of unqualified hospital personnel. There were not enough qualified male Registered Nurses to fill the demand. Others with limited or no qualifications had to be employed and trained on the job. Despite public criticism of this situation, it generally persisted because penitentiary officials were not willing to hire female Registered Nurses, whom they regarded as security risks in maximum-security institutions.[166] This problem and others would be examined thoroughly in the mid-1970s by a number of special medical advisory committees to federal correctional officials.

Introduction

The 1970s was a rocky decade in the federal corrections system in Canada. In April 1971 the worst riot in its history took place at the Kingston Penitentiary. The key administrative staff in the institution had been aware trouble was brewing there, but did not know when it would break out. For four days inmates controlled the key dome area and held as hostages six correctional officers. The riot only ended after a committee made up of inmates and citizens worked out a plan for the release of the hostages and the return of the inmates to normal custody. During this period of anarchy prisoners seething with rage over dehumanising and repressive conditions ran amok, smashing everything in sight. While the officers escaped physically unharmed, one inmate was murdered by the others. He was the victim of a kangaroo court for sexual offenders--the pariahs of the inmate world. Another inmate later died of his injuries.[1]

The loss of control shocked correctional officials and prompted a thorough investigation of the bloody rebellion and the causes behind it.[2] The three man inquiry under J.W. Swackhammer did not find any one particular cause to the disturbance, but concluded instead that it was the product of a failed system, unable to establish and maintain a strong rehabilitation program. Possible contributing factors were the aged condition of the institution, overcrowding, the shortage of professional staff, a substantially curtailed activity program, the presence of inmates not requiring maximum security, the lack of adequate channels and staff to deal with inmate complaints, and the fact inmates were overly confined to their cells.[3] In the five years prior to the riot security considerations in the maximum security institution had been used to justify a steady reduction in various priviledges and programs, to the point where security became a kind of psychosis. Inmates had to spend a minimum of sixteen hours a day in virtual isolation in their cells, in which they had little to do and were

severely restricted in the possession of personal effects.[4] Understandably, the report of the investigation emphasized the destructive effect of these conditions.

> The cumulative effect of these factors is, of course, first, to increase the likelihood that the inmate will become highly institutionalized and submissive to the inmate subculture, and second, to seriously impair his ability to adjust to the community at large upon release. In addition, and not without importance, such a regime does a real injustice to a human being and is destructive of whatever humanity may be within him in the event that the regime is merely "convenient" and not required, as we think it is not, by a legitimate object of the prison.[5]

Perhaps motivated by the nightmarish events at the Kingston Penitentiary, the Department of the Solicitor General took steps later that year to initiate a period of reform within the penitentiary system. A concerted effort was made "to alter the nature of the treatment of inmates from a punitive, or at best a highly custodial orientation, to a strongly rehabilitative orientation."[6] Jean Paul Goyer, then Solicitor General, stated the new policy to the House of Commons in October 1971.

> For too long a time now, our punishment oriented society has cultivated the state of mind that demands that offenders, whatever their age and whatever the offense, be placed behind bars. Even nowadays, too many Canadians object to looking at offenders as members of our society and seem to disregard the fact that the correctional process aims at making the offender a useful and law abiding citizen, and not any more an individual alienated from society and in conflict with it...Consequently, we have decided from now on to stress the rehabilitation of individuals rather than protection of society.[7]

The Department of the Solicitor General was well aware of the criticisms its new policy would face, for being too progressive or failing to protect society against dangerous criminals. Although a risky and demanding change, it was seen as preferable to keeping a system "which in itself can cause even more obvious dangers." It was also regarded as quite feasible and necessary, since "at least

80 per cent" of inmates could be rehabilitated and successfully returned to society; not to do so, it was argued, would be to continue a punitive policy that only met the needs of a minority.[8] To this end restrictions on inmate correspondence were considerably eased, inmate visiting rights with friends and families were expanded under less restrictive conditions and longer visiting hours, and community-based residential centres were set up. Another step in the same direction was the appointment by the Solicitor General in 1973 of a Correctional Investigator, to act as a prison ombudsman by investigating and making advisory recommendations on the complaints of prisoners.[9] The types of complaints which are examined include transfers between institutions, medical care, correspondence and visits, dissociation, discipline, sentence administration, and diet.[10]

However, in the early 1970s this policy of liberalizing Canadian penitentiaries was scarcely, if at all, successful in defusing tensions and making these institutions more humane places of incarceration. Between 1970 and 1976 unrest in the form of riots, strikes, murders, and hostage-takings dramatically increased in size and numbers each year. In 1975 and 1976 there were a total of sixty-five major incidents in federal penitentiaries. In September and October of 1976 the escalating cycle of violence climaxed with almost simultaneous disturbances at three institutions almost 3,000 miles apart. Over $2 million in damages was caused by these particular episodes. It became clear that the upheavals would not abate unless the causes were discovered and remedied. Accordingly in October 1976 the House of Commons agreed to the motion of the Solicitor General that the Standing Committee on Justice and Legal Affairs inquire into the penitentiary system in Canada. This inquiry was carried out over the next seven months by a Sub-Committee of the Standing Committee, made up of Parliamentarians.[11]

In its report the Sub-Committee on the Penitentiary System in Canada pointed to, in its opinion, the existence of a crisis in the system; one which could only be met by the immediate resort to large-scale reforms. Many problems were evidentand these were addressed by the sixty-five recommendations made in its report.[12] The Sub-Committee found that this crisis was "born of anger, frustration and oppression within the tight and unnatural confines of prison over unresolved grievances, transfers, harassment and provocation." Both staff and inmates (in adversary positions) described these occurrences as "mind games."[13] The Sub-Committee was particularly aware of the critical--but confused--role played by the correctional staff.

> Canadian penitentiaries began to be "opened up" several decades ago with the gradual abandonment of corporal punishment and the rules requiring silence and extended time in cells. These reforms also saw the introduction of programs of work and socialization that were novel, at least in Canada. Superimposing these new patches on what remained essentially a monolithic old systm did not, unfortunately, succeed in the bright hopes of their innovators--men and women, who, in retrospect, must be regarded as courageous public servants and political officials. Instead, the changes served primarily to require staff and inmates alike to behave in some ways that were inconsistent with the overwhelming thrust of our traditional system, without breaking down the core of repression upon which that system is built...The results of our first tentative attempts at correctional reform have therefore fallen between two stools with a consequent untoward impact on correctional staff. Their role has become confused, and many staff members--particularly more senior ones--tend to look back at the way things were before the time of change as some of golden age of regimentation in which everyone knew his place and what was expected of him...Much of the current union effort is devoted to throwing off the present stifling web of frustrating ambiguity by reinstitution, both on a person-to-person and on an institutional level, practices that have been officially abandoned or condemned by the Canadian Penitentiary Service for a decade. By and large, this effort has succeeded, and our correctional efforts, as opposed to our custodial practices, are consequently paralysed in the middle of this union-management deadlock.[14]

Understandably, the Sub-Committee called for better selection, training, and promotional opportunities for correctional officers.[15] Management functions also

required significant improvement. Too much authority, for example, had been taken away from the directors of institutions and assumed at the regional level.[16] As for inmates, there was a clear need for their legal rights to be respected. The Sub-Committee believed that the Rule of Law was basic to prison discipline, as it stated that, "The arbitrariness traditionally associated with prison life must be replaced by clear rules, fair disciplinary procedures and the providing of reasons for all decisions affecting inmates."[17] The correctional system also need to be made more open to the public except in respect to the needed or a legitimate degree of confidentiality regarding "sound and necessary correctional practices, including the protection of the privacy of inmates and employees."[18]

Since the report of the Sub-Committee in 1977 Canadian penitentiaries have not seen the same kind of dramatic unrest which sparked this investigation. Nonetheless prison life remains potentially explosive. In July 1982 three guards and two inmates died at the Archambault Institution, in the bloodiest riot ever in the history of the Canadian penitentiary system. And other problems remain as some inmates turn to alcohol, drugs, or self-mulitlation in order to ease the frustrations of prison life.[19] In light of such events it is easy to lose sight of the fact that the process of penal reform initiated after the second World War has continued in the late 1970s and 1980s. Inmates now spend more time than ever out of their cells, and have more visitor and correspondence privileges. There is also greater access to librairies and educational facilities, as well as to recreational and work opportunities.[20]

Another initiative taken by federal correctional officials has been the implementation of a code of inmate rights. This code has been issued in handbook form to each federal inmate since July 1980. It is designed to meet the United Nations Standard Minimum Rules for the Treatment of Prisoners, to which Canada is a signatory.[21] In this document the Correctional Service of Canada accepts "the

basic proposition that an inmate retains all the rights of an ordinary citizen save those which have been removed either by law, or by the necessary implication of incarceration." The only punishment to be inflicted upon the inmate is the deprivation of his liberty, as specified in the sentence imposed by the Court.[22] A further change towards the liberalization of the federal corrections system was the adoption in 1980 of the call by the Parliamentary Sub-Committee for the Correctional Service to be open and accountable to the public. This policy has been implemented through the Communications Branch of the Correctional Service of Canada, which is charged with maintaining effective communictions with various governmental and non-governmental officials and bodies and the general public.[23] Today the general public is allowed to see, more than ever, into the daily life of correctional institutions across the country.

The new emphasis on the Rule of Law in Canadian penitentiaries and the individual rights of prisoners has been parallelled by a new rationale taken by correctional officials. A new correctional philosophy emerged in the late 1970s because of the realization that rehabilitation and treatment were ineffective and an encroachment on basic human rights.[24] This was a development which also took place in other countries.[25] Based on the so-called "Program Opportunities Model of Corrections," the current philosophy states that the role of the federal corrections system is to provide program opportunities which will allow the offender, if he wishes, to contribute to his own self-improvement.[26] It is now regarded that previous approaches to penal practice, such as the separate or Auburn system of prison discipline, the reformatory movement of the late nineteenth century, and the treatment ideolgy of the post-second World War era, were in fact incorrect.

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*In 1978 the name of the Canadian Penitentiary Service was changed to the Correctional Service of Canada.

> Beyond the basic requirement of providing secure installations wherein offenders would pass their sentences, each of these penal philosophies had one other objective: the correction of all offenders. What they failed to take into account was that a person can be corrected only if he or she wants to be corrected - and not every inmate wants to be. The fact is, there is no no easy cure-all, no magic formula by which all offenders can be transformed into decent, law-abiding citizens.[27]

The demise of rehabilitation is just one sign of the great changes in the federal correctional system since the founding of the pre-Confederation Kingston Penitentiary. Instead of the fifty-five convicts held there at the end of 1835, there are now more than 11,000 inmates housed in the various institutions of the Correctional Service of Canada. The cost of their maintenance is not cheap, at more than $700 million per year.[28] Whereas until the end of the 1950s all of the penitentiaries had been maximum security institutions, now there are many levels of security for the confinement of inmates. These range from community residential centres to the ultra-maximum security Special Handling Units which were introduced in 1977. These Units are for inmates who have committed or who are thought likely to commit violent acts while incarcerated.[29] Their use reflects the fact that penitentiaries are now being used more for the incarceration of dangerous or persistent offenders, as the criminal justice system puts more emphasis on the use of alternatives to imprisonment for non-violent offenders.[30] The federal corrections system continues, therefore, to be a reflection of what society thinks it should be. Accordingly, its current role is punishment solely through the deprivation of liberty, instead of through a punitive environment.

Medical Services

The new emphasis on the civil rights of inmates has been reflected in the redevelopment of medical services in the Correctional Service of Canada since the early 1970s. By then it had become clear to federal correctional officials that the provision of these services needed to be brought up to fully modern

standards.[31] This new awareness was part of a trend in corrections in North America as the manifest lack of proper prison health care was revealed in many instances. Recent American court cases, too, had confirmed inmate charges that poor medical services constituted cruel and unusual punishment. One of the critics was Jessica Mitford, author of the widely-read exposé Kind and Usual Punishment which described the "prison business" in the United States. In the medical services area, it depicted such gross abuses of the civil rights of prisoners as their exploitation for the purposes of medical research and the overuse of drugs in attempts at the behaviour modification of prisoners.[32]

As the first step in the needed reforms in the provision of correctional health care services the federal Solicitor General and the Canadian Penitentiary Service requested the professional advice of individuals belonging to professional health care bodies in Canada. The Advisory Board of Psychiatric Consultants was the first such group and was appointed in August 1971. Its eight members where chosen by the Solicitor General from nominations made by the Board of Directors of the Canadian Psychiatric Association.[33]

There was an imperative need for the advice of the Psychiatric Consultants. As early as 1963 the annual report of the Canadian Penitentiary Service had identified the existence of a shortage of psychiatrists and psychologists, which was preventing the needs of most institutions from being met adequately.[34] Another indication came in 1966 when a John Howard Society official testified before a Parliamentary Committee that there were some inmates who had to be segregated in isolation because there were no facilities for their psychiatric treatment.[35] By 1970 the continuing high demand and need for psychiatric treatment had created a difficult situation as individual psychiatrists working in the penitentiaries were increasingly overloaded with work.[36]

The report of the Canadian Committee on Corrections, which was handed down in 1969 (commonly known as the Ouimet report, after its chairman), pointed to

another difficulty in the area of penitentiary psychiatric services. It was stated that in most parts of Canada the transfer of mentally disordered inmates to provincial psychiatric hospitals could be effected because of sufficient cooperation between the relevant federal and provincial authorities. Yet an old and very troubling problem remained. There were cases in some jurisdictions where the provincial authorities simply would not accept these inmates for treatment. Instead they argued that the responsibility for providing these psychiatric services lay with the penitentiary system. Like the Archambault Royal Commission report of 1938, the Ouimet report found that there was serious cause for concern about this situation. The latter stated "that there is no room for intergovernmental dispute of this kind." It regarded as desirable the provision of addititional psychiatric resources by the federal Government, which could also house provincial inmates where those jurisdictions did not have sufficient resources or demand to support an adequate treatment program.[37] This serious problem was one of the reasons behind the establishment of Regional Psychiatric Centres in the 1970s.[38]

After eight months of investigation the Advisory Board of Psychiatric Consultants handed down its report in May 1972. It drew attention to long-standing problems in the delivery of psychiatric services to federal prisoners. Deficiencies were noted in the classification of the mentally ill, inadequate facilities, overcrowding, and a lack of qualified personnel for the care and treatment of patients. The Board called for a unified psychiatric service in each Region of the Canadian Penitentiary Service, which would be sensitive to local differences in needs, programs, and facilities. The Psychiatric Consultants envisioned a system of Regional Psychiatric Centres. These would provide treatment for acute, sub-acute, and chronically ill mental patients and also supply opportunties for research, training, and the improvement of professional standards in forensic psychiatry.[39]

The establishment of Regional Psychiatric Centres in the Canadian Penitentiary Service was not an entirely new idea. Regional Medical Centres with psychiatric facilities were part of the ten year penitentiary construction plan initiated in 1963, under the direction of Commissioner of Penitentiaries Allen J. MacLeod.[40] These Centres had been called for by the Correctional Planning Committee report of 1959, which had a chapter devoted to medical services. It was the intention of the report's authors that each region of the penitentiary system should have a full complement of services for those in need of specialized treatment facilities. To this end planning went ahead for Regional Medical Centres in British Columbia and Saskatchewan. However, by the 1960s Government funding for the Penitentiary Service dropped sharply, and until the mid-1970s there was no money for more staff or institutions.[40a] It therefore took until June of 1972 for the first of these facilities to open, at Abbotsford, British Columbia. It is located in the former female unit of the Matsqui Penitentiary, which was renovated for its new purpose. This centre had originally been planned as part of an $18 million penitentiary complex at Mission, British Columbia. It was to have comprised a reception Centre, a psychiatric Centre, and minimum and maximum security institutions. However, the construction of the complex was halted in 1971 because the anticipated 4% annual increase in penitentiary population, forecast in the ten year penitentiary construction plan, did not occur. In addittion, its design was regarded as "too oppressive" and not in line with the requirements of modern criminology.[41]

By September 1975 two more psychiatric centres were in operation, at Ville de Laval, Quebec and at Kingston, Ontario. The Quebec centre comprised part of the Correctional Development Unit at the Laval (formerly St. Vincent de Paul) Penitentiary complex. A fourth was under construction in Saskatoon, Saskatchewan. A centre for the Atlantic Region, to be operational in 1980, was being planned for the Halifax area, near the provincial mental hospital.

Discussions were also about to start between Quebec officials and their federal counterparts on the provision of medical and psychiatric services to federal inmates, in recognition of the existence of provincial facilities now available and the need to avoid duplicating these scarce resources.[42]

In April 1977 the talks between Quebec and federal officials were concluded with an agreement to contract the services of the Philippe Pinel Institute to the Quebec Region of the Canadian Penitentiary Service. It is a 283 bed provincial psychiatric hospital. In 1983, for example, this agreement covering the approximately 3,500 inmates in the Quebec Region allowed for 32,120 hospital days for the year, or an annual capacity of eighty-eight inmates per day.[43] The plans, however, for a psychiatric centre in the Atlantic Region were not realized. It was announced in September 1978 that the proposed centre was too expensive; the daily cost for each patient would have made it one of the most expensive hospitals in North America. The alternative policy adopted has been to continue to treat mentally disordered inmates in the institutions or to refer them to provincial facilities.[44]

The most modern of the Regional Psychiatric Centres was opened at Saskatoon in November 1979. The 106 bed $10 million facility is affiliated with the University of Saskatchewan, and occupies a fifty-five acre site near the main campus of that institution. It provides hospital care for federal inmates in the Prairie Region and for inmates from provincial institutions in Saskatchewan who are in need of specialized treatment. In addition, the Centre provides opportunities for research and training in psychiatry, law, medicine, sociology, and criminology. Security is an important consideration there because the Centre, like its counterparts, is a multi-level security institution. An electronic security system is in use, with supersensitive electronic cables interwoven throughout the double 5.2 metre chain link fences.[45]

Another new psychiatric facility was to have been built in the Ontario Region, as part of a new regional medical facility to be located at the Collin's Bay Penitentiary near Kingston. In 1976 this facility was tentatively scheduled to be completed in 1979. However, construction of the complex did not get past the site preparation stage as budgetary restrictions forced the shelving of the project in 1980. The new psychiatric facility would have replaced the one in the in the East cell block or old Prison of Isolation at the Kingston Penitentiary, which has been used for this purpose since 1959.46

In November 1982 the Ontario Regional Psychiatric Centre was renamed the Kingston Penitentiary Treatment Centre. This change was the product of an eight month study that year by a team of Toronto consultants charged with analyzing the psychiatric services provided by the Correctional Service of Canada. In the first comprehensive evaluation since the report of the Advisory Board of Psychiatric Consultants ten years earlier, the consultants looked at the inmate clientele, costs and resources, staff needs and available facilities, and alternative delivery methods. The study pointed to a new multi-disciplinary approach to mental health care, instead of only treating psychiatric illnesses. Behind this conclusion was a decade of experience, together with present trends in psychiatric care which "favour the small, urbanized multi-treatment centre rather than larger, isolated hospitals." In this context the Regional Treatment Centre inside the Kingston Penitentiary became a model for this new concept. Formerly a separate institution, it is now part of the Kingston Penitentiary.47

Besides providing guidance for the improvement of psychiatric services the report of the Advisory Board of Psychiatric Consultants served as a catalyst for the further reform of medical and health care services in the Canadian Penitentiary Service.48 Since 1972 extensive changes have been made in the areas of medical, dental, nursing and allied health care services in federal institutions. A basis for these changes has also been provided by the advice of

outside consultants. The first of these groups appointed after the Psychiatric Consultants was the Nursing Advisory Committee in March 1972. It was chaired by the Nursing Advisor to the Director of Medical Services, also appointed in March 1972, and included representatives from the Canadian Nursing Association, the Department of National Defense, and the Department of Health and Welfare. Its mandate was to advise on the role of the hospital officer in the Canadian Penitentiary Service and on the development of training programs. The committee developed an equivalency test and a three to six week training program for hospital officers, which was implemented by the Regional Nurses appointed in the Quebec, Ontario, and Western Regions. Continuous in-service training comparable to a Registered Nursing Assistant's course was also started as part of the increased emphasis being placed on the standard of professional nursing service.49

The work of the Nursing Advisory Committee was enlarged on by the National Health Services Advisory Committee, appointed in May 1973 by the Solicitor General. Its seven members were drawn from nominations made by the Canadian Medical Association, the Candian Dental Association, the Canadian Psychiatric Association, the College of Family Physicians of Canada, and the Canadian Nursing Association, with the Director of Medical Services serving in an ex-officio capacity. The main terms of reference of the Advisory Committee were to review, with a view to recommendations for changes, the policies, organization, and administration of health care services in the federal correctional system. The major thrust of their interim and final reports, issued in June 1974 and in November 1975, was the call for these services to be provided by a provincially registered staff of professionals. In this way a "humane health services" comprising medical, psychiatric, dental, nursing and allied health care services would "contribute directly and indirectly to the efforts of inmates to rehabilitate themselves."50

The two reports of the Health Services Advisory Committee were a clear signal that a new era had started in inmate health care. It was obvious, too, that radical changes were necessary if the inmate, by right, was now to receive a level of health care equivalent to that in the outside society. The Advisory Committee stressed that it was the duty of health care staff to care for the inmate, who deprived of his freedom, was unable to obtain these services on his own. To do otherwise would be to provide an unequal and lower standard of care.[51]

As the first step in achieving this goal a new organizational and administrative structure was needed for the provision of medical and health care services to federal inmates. Therefore in April 1975 the Division of Medical Services, which had been part of the Inmate Programs Brach, was elevated to branch status. As a result the Director of Medical Services in the Penitentiary Service became the Director General of the Medical and Health Care Services Branch, reporting directly to the Commissioner of Penitentiaries. Appropriate changes were also made at the regional and institutional levels. The effect of this change was to provide professional autonomy to the health care staff.[52]

Vital to the reforms advocated by the National Health Services Advisory Committee was a larger role for the nursing profession than in the past. This was to be done by using more Registered Nurses, in order to be able to improve the level of services provided and to replace those hospital officers not qualified to carry out the screening of sick parades.[53] It is worth noting that this was a far from new suggestion. In 1914 a Royal Commission investigating the state of affairs at the Kingston Penitentiary had recommended that trained nurses be appointed for the actual nursing work, instead of having convict orderlies perform this work with the two hospital overseers in charge of the management of the hospital.[54] Again, in 1930 an American surgeon and hospital administrator had called for the employment of male or female graduate nurses, instead of

attendants and orderlies, in Canadian penitentiaries.[55] The Archambault Royal Commission did not comment on the situation in its 1938 report; however, a direct result of its report was a investigation in 1942 by the Department of Pensions and National Health which examined the medical and health care services at all the penitentiaries. It, too, identified the need for graduate nurses to be employed. This policy was adopted at the time, although it was difficult, if not impossible, to obtain qualified applicants during the war.[56] The recommendation to introduce Registered Nurses was again made in 1971 by the McLean-Riddell report to the Commissioner of the Canadian Penitentiary Service.[57] Certainly few Registered Nurses had ever been hired; when the National Health Services Advisory Committee started looking at the situation it found almost all the Registered Nurses were working in the newly-established Regional Psychiatric Centres.[58]

Whatever their lack of training and experience many hospital officers were resourceful and capable individuals who had served the penitentiary service in a dutiful and loyal manner for years. But after the interim report of the National Health Services Advisory Committee was issued their days were numbered. The Penitentiary service started gradually eliminating them through a process of attrition. In August 1974 about one-sixth (53) of the nursing staff were registered nurses; a year later this figure had risen to almost one-quarter (76).[59] Also, a select number of Health Care Officers, as they were now designated, were given the opportunity to upgrade their training through paid educational leave. It has been a matter of great pride to the present Health Services Advisory Committee that sixteen of these have returned to the institutions as fully qualified Registered Nurses.[60] Finally, in 1981 a Treasury Board decision eliminated the hospital officers group, and the remaining members were immediately replaced by Registered Nurses.[61]

Dental services to inmates was another major area of concern pointed to in the first report of the National Health Services Advisory Committee. In the

annual reports of the Canadian Penitentiary Service during the late 1960s and early 1970s these services were said to be satisfactory, apart from staff shortages and heavy workloads in some areas.62 The Advisory Committee, however, was not so uncritical. It pointed out that the incidence of dental disease (i.e. gums and decay) among inmates is very high, probably due to very few inmates previously having dental care. Penitentiary dental services were badly in need of reform, a situation that was not regarded as surprising because only since the start of the 1970s had dentistry generally been seen as an important part of the medical picture. All dentists were carrying a heavy workload, to the point of being overwhelmed. Aging or obsolete equipment located in inadequate quarters was another common difficulty. Other problems were found at one or more of the six institutions visited (Collins Bay, Millhaven, Joyceville, Dorchester, Springhill, and the Regional Reception Centre at Kingston): no dental assistant, no x-ray facilities, no dark room, a waiting list of fifty to sixty patients, no proper dental history available for patients, and inadequate security for dentists. Nor was a standard dental chart in use as dentists made use of their own individual dental chart; it was a situation which made for difficulties if statistical work on dental care was to be done, a possibility foreseen by the Advisory Committee.63

These many shortcomings in dental services helped to produce a low level of morale among penitentiary dentists. The situation was worsened by the fact dentists had trouble communicating with the Penitentiary Service about their professional needs, because the latter was not familiar with the aims and techniques of modern dentistry. In the early 1970s a number of young dentists who were recent graduates joined the Penitentiary Service, and they were not content to accept dental practices that they considered outdated. To get these changes accepted was an uphill battle until the National Health Services Advisory Committee appeared on the scene. The welcome dental reforms it inaugurated form

the basis of present dental care policy in the Correctional Service of Canada.[64] Difficulty, for example, had been encountered in trying to introduce a more hygienic type of toothbrush. Dr. Gary G. Osborne, part-time dentist at the maximum security Millhaven Institution near Kingston, recalls that

> ...the type of toothbrush in use until 1974 was designed more for cleaning shoes than for cleaning teeth. When a dentist tried to change the brush to a more acceptable model the procedure was to determine the size of the nylon bristle, diameter and the length, the number of bristles per tuft, the number of tufts per row, the number of rows per brush, and then came the handle.[65]

Another impetus for dental reform in the early 1970s was that while in custody prior to sentencing inmates were receiving more dental treatment, including extensive periodontal treatment and crown and bridge work. These inmates, like others in the 1970s and 1980s, are aware of what constitutes good medical and health care and have demanded it. Dentists were also calling for a different approach to treatment, emphasizing prevention instead of simply controlling pain by extractions as well as providing dentures for patients. Because of the work of the National Health Services Advisory Committee the guidelines now followed by dentists stress preventive care, operative dentistry, and periodontal treatment more than prothesis and the removal of teeth. Inmates are now seen regularly by dentists, and check-ups after the initial examination upon reception into the penitentiary system form an integral part of the health care system. Previously many inmates had never received dental care; now this is seldom the case. Aging or obsolete equipment has been replaced, and instead of using penitentiary hospital officers dentists now have their own dental assistants accompanying them into the institution.[66] These and other changes in dental care represent a "vast improvement" over conditions prior to the work of the Health Services Advisory Committee. The result has of course not only been better treatment for inmates but also a boosting of morale among penitentiary dentists to the point where the latter are glad to work for the Correctional Service of Canada.[67]

The recommendations of the first report of the Health Services Advisory Committee were enlarged upon by its second report, presented to the Commissioner of Penitentiaries in November 1975. It thoroughly studied how inmates were provided with medical and health care services in the Canadian Penitentiary Service, making seventy-six recommendations in addition to the forty-eight made in the first report. Among the subjects covered by these latter recommendations were the policy and administration of the medical and health care services branch; the development of regional medical and health care services reception centres; budgets and cost-effectiveness; staff performance and evaluation; medical record-keeping; the policy, administration, and scope of services in the institutional health care centre; the desirable number and use of hospital beds; hygiene and sanitation; medicine (drugs); the personal and professional requirements for health care centre staff; and nursing services and staff.68

Many of these recommendations emphasized the role of the institutional physician, who, as the Advisory Committee believed, "must be held responsible for the administrative direction and medical and health care services provided by the medical and health care staff of the institution."69 Also stressed was the continuing input of health care professionals from the community. In this context, one recommendation of the first report of the Advisory Committee which had not been implemented yet and was again called for was the provision of a group of national consultants to the Director General, Medical and Health Care Services Branch of the Canadian Penitentiary Service. This group was never in fact appointed. Instead, what was appointed in 1978 was a Medical and Health Care Advisory Committee. This group, representing general medical care, psychiatry, dentistry, and nursing is mainly composed of former members of the Advisory Committeee. Besides reviewing all the recommendations of its predecessor, very few of which are not fully or partially in place today, the

Medical and Health Care Advisory Committee provides independent professional advice to the Correctional Service's medical and health care activities.[70]

Following less than two years after the final report of the National Health Services Advisory Committee was the report to Parliament in March 1977 by the Sub-Committee on the Penitentiary System in Canada. Among their many findings was that medical facilities differed widely from one institution to another. In the newer penitentiaries, such as Archambault, the level of care was "quite adequate," but at some of the older penitentiaries it was regarded as "completely unsatisfactory." Cited as a prominent example of the latter was the British Columbia Penitentiary. Inmates, it was asserted, did not have ready access to outside hospitals, and therefore those not ill enough to need outside hospitalization deserved an adequate level of care from the Penitentiary Service.[71] In response to this judgment Dr. Dan Craigen, the Director General of the Medical and Health Service Branch, was not critical of the aim of the report, agreeing that the level of health services was unequal among Canadian penitentiaries. At the same time he pointed to the progress made in improving medical and health care services, much of which was due to the work of the National Health Services Advisory Committee.[72]

In an effort to redress this imbalance in the level of health care services among institutions the Canadian Penitentiary Service adapted in March 1977 a new Policy and Procedures Manual for all medical services to inmates in the system. It was developed in accordance with the Directives of the Commissioner of Penitentiaries and the two reports of the National Health Services Advisory Committee. Its aim is to provide an improved and standardized level of treatment and care for all inmates, together with better information about and control over medical services for Correctional Service management. Not only does this provide health care staff with a well-defined method of operations, it represents a pioneering achievement in establishing standards for health care in Canadian correctional institutions.[73]

A related development in December 1977 was the establishment of ethical principles for inmate health care services in federal correctional institutions. These were published along with the new Policy and Procedures Manual for health care staff. The subjects covered by the twenty-seven principles include the initial medical examination upon entry into the system, the nature of medical services to be provided, the continuity of medical care, the right to accept or refuse treatment, the confidentiality of information obtained by health care staff, the role of the health care staff in classification and parole, psychiatric treatment, and medical research. All inmates at reception are required to submit to a medical examination, and an annual one is available at their request. Unless they consent to the procedure, they do not have to undergo diagnostic tests which involve significant discomfort or risk. An inmate voluntarily seeking treatment may refuse consent to any specific form of therapy except as required by provincial law. Importantly, it is stressed that health care professionals are operating in the "context of a therapeutic relationship." As in the outside society, they must respect the confidentiality of the information obtained from the patient. Confidentiality is to be breached only with the patient's consent or when they become aware of "threats or intentions which they judge likely to be carried into action that are dangerous or a threat to the safety of others."[74]

The basis of these ethical principles was developed at a conference held in Kingston, Ontario in 1975 by the Department of the Solicitor General. It was convened in order to provide "a multi-disciplinary cross section of concerned and informed Canadians with a forum to express their opinions on the eithical aspects of health care in the Canadian Penitentiary Service." Input into the principles also came from the Ethics Committee of the Canadian Medical Association, who were in agreement with them. On the institutional level the adoption of these principles has not been imposed arbitrarily, but instead has been left to the conscience and judgment of health care professionals.[75]

Four of the sixty-three recommendations of the Sub-Committee on the Penitentiary System in Canada concerned medical services to inmates. One of these recommended that controlled epileptics not be excluded from minimum security institutions, as this Divisional Instruction was strongly regarded as unfair. This recommendation was agreed to in priciple, so long as it was considered by the Director General of the Medical and Health Care Services Branch and his senior medical staff that adequate medical services were available at the institution where the inmate was being sent.[76] Another recommendation by the Sub-Committee echoed the serious concern by the National Health Services Advisory Committee over the use and distribution of medications or drugs. Adequate record keeping of the drugs dispensed was called for in order that control could be exercised over the amount used. Both investigating bodies had found evidence that at some institutions drugs were being distributed in extremely large quantities as well as being hoarded by some inmates for their own use. In response to the obvious need for better drug control in health care centres the Penitentiary Service instituted a new drug monitoring system in 1978. It provides for the recording and monthly reporting of the amounts and kinds of prescribed drugs used by inmates.[77]

The two other recommendations by the Parliamentarians related to psychiatric care. One urged the adoption of the "social therapy" technique in minimum and maximum security institutions. This technique was developed by the Oak Ridge Division of the Ontario Mental Hospital at Penetanguishene. There the patients conduct group therapy among themselves, simulating "the situations and actions that led them to committing the criminal acts." It is claimed that in this model it has been found there is an absence of hostility in the patients, as opposed to that in penitentiaries, and that patients accept responsibility for past behaviour. In response to this recommendation the Correctional Service of Canada

Canada opened a thirty bed unit in the Regional Psychiatric Unit at Abbotsford, British Columbia in 1979, using it as a pilot project in order to evaluate this psychiatric model.[78] At the medium security Springhill Instutition in Nova Scotia a therapeutic community has been in operation since 1969. The 102 cell unit is managed by the Offender Programs Branch of the Correctional Service, and the institutional psychiatrist who helped establish the program continues to meet regularly with the staff of the therapeutic unit.[79]

The other recommendation of the Sub-Committee regarding psychiatric care urged that Regional Psychiatric Centres be placed under the jurisdiction of the federal Department of Health and Welfare. Also called for were discussions with the provinces in order to avoid the duplication of mental health services. The Sub-Committee regarded provincial mental hospitals or the Regional Psychiatric Centres as providing less than adequate treatment for mentally ill offenders. In response the Solicitor General pointed out that it was the provincial authorities, not the Department of Health and Welfare, who were responsible for the direct delivery of these services. Furthermore, it was noted that close cooperation between federal and provincial authorities was already Canadian Penitentiary Service policy; evidence of this was in the 1977 agreement to contract for the services of the Philippe Pinel Institute in Quebec, the continuing use of the Mental Health Centre at Penetanguishene, and the planned Regional Psychiatric Centre in Saskatoon for the treatment of both federal and provincial inmates.[80]

Further improvements have taken place in medical and health care services in federal correctional insitutitons since the work of the National Health Services Advisory Committee was finished. On the administrative side developments in this area include the standardization of inmate health care records; a new financial coding method for budgeting; and the evaluation of all health care centres in the

interest of securing accreditation, subject to criteria acceptable to the Canadian Council on Hospital Accreditation. To achieve and maintain this rating is the long-range goal for all health care and psychiatric centres in the Correctional Service in Canada. In 1977 the Regional Psychiatric Hospital in Abbotsford, British Columbia was the first to be accredited by the Canadian Council on Hospital Accreditation; since then several health care centres have met this goal. In addition, fifteen health care centres have gained accreditation by meeting specific international standards stipulated by the Commission of Accreditation for Corrections, as part of an accreditation program for federal correctional insitutitions and parole offices since 1978.[81]

On the institutional level, more emphasis has been put on the use of a wide range of medical specialists in order to achieve a high standard of care. Their services have been on a contract basis, like the institutional physicians, except for those hired as civil servants before this new policy went into effect in the mid-1970s. As well increased use has been made of community medical services for diagnosis, treatment, and rehabilitation in cases where the institutional health care centres possess inadequate resources. However, the resort to outside hospitals for in-patient and out-patient care has not been without its problems. Besides the high cost involved in transporting inmates, security concerns have presented obstacles which have had to be overcome. In the Ontario Region, for example, problems such as inmates escaping led the Kingston General Hospital to refuse to treat inmates in the late 1970s.[82] The solution to such difficulties has been to construct secure areas within community hospitals, like at the Cité de la Santé de Laval in Quebec. There a specially designed semi-private hospital room provides lodging for inmates who have to be confined in a maximum or super-maximum security setting.[83] Since October 1983 the security teams in these community hospitals have been made up of experienced correctional officers,

except for in the Prairie Region here the institutions are too scattered for the effective use of a team. Previously a combination of correctional officers and commercial security guards were in use, but the contracts of the latter were not renewed because of legal considerations.84

The new emphasis on a high quality of fully professional medical and health care services in Canadian penitentiaries in the 1970s and 1980s has also meant the encouragement of professional development among health care staff. Nurses have taken upgrading courses, such as learning about administration or keeping up to date or ahead of current developments in the medical field.85 Opportunities have been provided for interchange with others involved in correctional health care, on the regional, national, and international levels. The first national conference of health care professionals took place in Ottawa in mid-May of 1983, bringing together Assistant Wardens and their colleagues in the Medical and Health Care Services Branch of the Correctional Service of Canada. It was an important forum for the divergent views of the participants. Among the subjects dicussed at the three day meeting were fiscal restraint and essential services, security, budgets, medical records, evaluation of services, and drug and alcohol addiction. In view of the economic recession fiscal restraint dominated much of the discussions.86

In August 1983 Canadian correctional health care professionals had the opportunity to meet in Ottawa for four days with international colleagues at the 2nd World Congress on Prison Health Care. Planning for the event had been underway since the fall of 1980. The over six hundred delegates from more than forty-five countries heard papers on such issues as policy; standards; psychopharmacology; mental health care; alcohol, drugs and violence; the role of the nurse; law and ethics; alien offenders; and female offenders. Canadians were well represented among the over one hundred experts who spoke there. All in all, it was a rich opportunity for dialogue among correctional health care professionals.87

In the period since 1970 the provision of medical and health care services in Canada's federal correctional institutions has become fully professionalized. Today 515 health care staff members provide health care through twenty-six health care centres serving forty-one major institutions, and two Regional Psychiatric Centres and a Regional Treatment Centre. Health care will take up about seven per cent of the operating budget of the Correctional Service in the 1983-84 fiscal year, a share estimated at $38.9 million. The health care staff will handle an estimated 464,200 general clinic visits during the current fiscal year to health care centres. Inmates now receive a level of care which is close to being comparable to that in a community clinic.[88]

Yet for all the emphasis in the past decade of the delivery of high quality professional health care services in federal correctional institutions, the fundamental ambiguity of penal health care exists today just as it did at the pre-Confederation Kingston Penitentiary. Canadian penitentiaries continue to function as places of "long-continued personal restraint," with tension existing between the correctional staff and the inmates as the possibility of violence remains ever-present. Health care staff are prison staff, too, and despite their professionalism they can get caught in the middle between being a healer and a disciplinarian. This hidden reality was starkly revealed in 1982 when a hostage-taking took place at the maximum security Edmonton Institution. One of the female nurses was among the five hostages. It was a "traumatic" experience for her, but some of her co-workers were more affected by the event. Anger and disappointment was their reaction as "we felt let down because we've always tried to treat the inmates as human beings first," as one said.[89] Also, malingering is still a problem just as it was a century ago, and the correctional nurse has to decide if an inmate is trying to escape work.[90] But in spite of such difficulties health care staff in Canadian penitentiaries today are dedicated professionals. In 1983, just as much as a century before, their work remains an essential part of penitentiary operations.

Conclusion

It has been nearly a century and a half since the founding in 1835 of the Kingston Penitentiary, the cornerstone of the federal correctional system in Canada. In this period modern Canada has emerged out of the colonial society of British North America which had resorted to the penitentiary as a more effective form of punishment than existing methods. The practice of medicine, too, has undergone huge changes since this pre-industrial age. Effective public health measures undertaken in the nineteenth century meant that the danger of such loathsome diseases as cholera and smallpox faded away. Further progress against prevalent infectious diseases came in the 1940s with the development of antibiotics which effectively cured and helped to eradicated cases of two age-old medical problems, tuberculosis and venereal disease. Great changes have also taken place, some gradually and some swiftly, in the fields of general practice, psychiatry, and dentistry. All of these developments have been reflected in the provision of medical services in the federal correctional system.

At the same time these medical services have always been closely tied to the character of the federal correctional system. When penitentiary conditions have worsened over a period of time, the quality of medical services has often suffered at the same time. Until the late 1930s these services were basically oriented to the maintenance of the prisoner's health, so that it would not suffer under confinement. After that a new approach to the rehabilitation of the prisoner, through individual treatment instead of treating all prisoners alike, was carried out through the mechanisms of classification, education, vocational training, and socialization. Psychiatric services were then introduced in the 1940s and 1950s and they had a strong role to play, by helping the inmate to overcome emotional problems which might prove to be a stumbling block to his rehabilitation. However, this era would not last for more than a few decades. Since about 1970 the stress on individual treatment has been replaced by the

emphasis on the civil rights of inmates, and in line with this a high quality of medical services has been seen by correctional officials as a fundamental right of inmates. The provision of medical services has also been related to the historic federal-provincial jurisdictional split over penal services, as embodied in the proviso that offenders sentenced to two years or more in prison be sent to a federal penitentiary. This fact has made difficult the achievement of unity on many major issues of national policy, and in the medical services area the problems created by it are most obvious in the treatment of mentally ill offenders.

The story of penitentiary medical services also says much about the day-to-day reality of the correctional environment. Most notably, right from the early years of the Kingston Penitentiary malingering has always been a problem. It is an integral part of the relationship between the kept and the keeper, a game in which the motivation of the former--whatever this may be--forces the latter as healer to act the part of the disciplinarian. The result has always been a fundamental but albeit necessary perversion of the traditional doctor-patient relationship, with its customary element of trust absent. Nonetheless ever since 1835 a countless number of male and female correctional staff have delivered medical and health care services to the inmates and staff of the federal correctional system. Most of these persons have carried out their duties in a dedicated fashion, while in the case of some their competence has left something to be desired. Whatever the situation and the reasons behind it, the story of the development of medical services in the federal corrections system since 1835 is a rich one which says much about the history of Canadian penitentiaries, of Canada itself, and of the evolution of modern medicine.

Notes to Part One, Chapter One

1. Anglo-American, 1, 2, August 1852, 97-101, quoted by Frederick H. Armstrong and Neil C. Hultin, "The Anglo-American Magazine Looks at Urban Upper Canada on the Eve of the Railway Era", in Edith G. Firth, ed., Profiles of a Province. (Toronto: Ontario Historical Society, 1967), 51.

2. Report to Parliament by the Sub-Committee on the Penitentiary System in Canada. (Ottawa, 1977), 11.

3. Rainer Baehre, "Origins of the Penitentiary System in Upper Canada", Ontario History 69 (1977): 185-89.

4. J.M. Beattie, Attitudes Towards Crime and Punishment in Upper Canada, 1830-1850: A Documentary Study. (Toronto: Centre of Criminology, University of Toronto, 1977), 8.

5. Ibid., 8-9.

6. Baehre, "Origins of the Penitentiary System in Upper Canada", 186-89; J. Alex Edmison, "Some Aspects of Nineteenth-Century Canadian Prisons", in W.T. McGrath, ed., Crime and Its Treatment in Canada Second Edition. (Toronto: Macmillan, 1976), 348.

7. "Report of the Select Committee on expediency of erecting a penitentiary", Journals of the House of Assembly of Upper Canada, 1831, Appendix, 231 (hereafter cited as Report, 1831). Quoted by Michael S. Cross, "Imprisonment in Canada: A Historical Perspective", Community Series 1, No. 6. (Toronto: John Howard Society, 1976[?]), n.p.

8. Beattie, Attitudes Towards Crime and Punishment, 9-10.

9. Baehre, "Origins of the Penitentiary System", 188.

10. Ibid., 186; Beattie, Attitudes Towards Crime and Punishment, 10.

11. Baehre, "Origins of the Penitentiary System", 189-90.

12. David J. Rothman, The Discovery of The Asylum. (Boston: Little, Brown and and Company, 1971), 57-59.

13. Baehre, "Origins of the Penitentiary System", 188-189; For a detailed view of the backgrounds and careers of Charles Duncombe, John Macaulay, and Hugh Thomson, see Ibid., 184-96. These men were the prison's chief promoters.

14. T.E. Brown, "Living with God's Afflicted: A History of the Provincial Lunatic Asylum at Toronto, 1830-1911", (Ph.D. thesis, Queen's University, 1981), 59.

15. Baehre, "Origins of the Penitentiary System", 188-89.

16. Rothman, The Discovery of the Asylum, 82-83, quoted by Baehre, "Origins of the Penitentiary System", 189.

17. Rothman, The Discovery of the Asylum, 79-82; Annual Reports of the Prison Discipine Society, Boston. Originally Published 1826-1854, (Montclair, New Jersey: Patterson Smith, 1972), 1: xii-xv.

18. Cross, "Imprisonment in Canada", n.p.

19. Beattie, Attitudes Towards Crime and Punishment, 22.

20. Ibid.

21. Report, 1831, 231.

22. Beattie, Attitudes Towards Crime and Punishment, 22-23.

23. Michael Ignatieff, "State Civil Society and Total Institutions: A Critique of Recent Social Histories on Punishment", in Michael Tonry and Norval Morris, eds., Crime and Justice 3 (1981): 170.

24. Idem., A Just Measure of Pain. (New York: Macmillan, 1978), 44.

25. Rod Morgan, "Divine Philanthropy: John Howard Reconsidered", History 62 (1977): 392. Among the recommendations Howard made for prison reform was the installation of baths to remove dirt, of ovens to delouse clothing, and the use of ventilators and infirmaries to help eliminate the presence of infectious diseases. See Ibid., 398.

26. Ignatieff, A Just Measure of Pain, 61. For an example of the hygienic aims of humanitarian reformers, see Sketch of the Origin and Results of Ladies' Prison Associations. (London, 1832). A description of the unhealthy gaol conditions which they decried can be found in Anthony Babington, The English Bastille. (London: Macdonald, 1971), 7-9, 63-65, 83-88. However, some eighteenth-century historians have recently questioned whether the pre-reform prison was as unhealthy and squalid as prison reformers made it out to be. See Ignatieff, "State, Civil Society and Total Institutions", 163.

27. Baehre, "Origins of the Penitentiary System", 200-201.

28. William Christopher George Norman, "A Chapter of Canadian Penal History: The Early Years of the Provincial Penitentiary at Kingston and the Commission of Inquiry into its Management,1835-1851", (M.A. thesis, Queen's University, 1979), 1.

Notes To Part One, Chapter Two

1. Anthony Babington, The English Bastille (London: Macdonald, 1971), 7-8, 63-64; For a study of the anatomization of convicts in eighteenth-century England, see Peter Linebaugh, "The Tyburn Riot Against the Surgeons", in Douglas Hay et al., Albion's Fatal Tree. (New York: Pantheon, 1975), 65-117.

2. Rod Morgan, "Divine Philanthropy: John Howard Reconsidered", History 62 (1977): 404.

3. W.J. Gray, "The English Prison medical service: its historical development and more recent developments", in A Ciba Foundation Symposium, Medical Care of Prisoners and Detainees. (London: Elsevier, 1973), 133; "Penitentiary Act", Statutes of England, 1779, Cap. 74, sec. 44.

4. John Howard, The Works of John Howard, Esq., 2 vols. (London, 1792), 1:29.

5. Margaret Angus, "Sampson, James", in Dictionary of Canadian Biography. Vol. 9 (1861-1870), (Toronto: University of Toronto Press, 1976), 699-701.

6. "An Act to provide for the Maintenance and Government of the Provincial Penitentiary, erected near Kingston, in the Midland District", Statutes of Upper Canada, 1834, Cap. 37, sec. 1, 7.

7. Ibid., sec. 24.

8. "Report of the Commissioners on Subject of Prisons and Prison Discipline", Journals of the House of Assembly of Upper Canada, 1836, Appendix 1: No. 71; Rainer Baehre, "Origins of the Penitentiary System in Upper Canada", Ontario History 69 (1977): 165-69.

9. Public Archives of Canada (hereafter cited as P.A.C.), RG13 C3 Vol. 1049, Minutes of the Board of Inspectors of the Provincial Penitentiary, September 30, 1835.

10. P.A.C., RG13 C3 Vol. 1049, Minutes, September 30, 1835, October 15, 1836; Museum of the Staff Induction Centre, Correctional Service of Canada, Kingston, Ontario (hereafter cited as M.S.I.C.), Minutes of the Board of Inspectors of the Provincial Penitentiary, October 12, 1847; The annual reports of the penitentiary surgeon can be found as part of the annual penitentiary report. For 1835-39 see the Journals of the House of Assembly of Upper Canada, except for 1838 which can be found in manuscript form in RG13 C3 Vol. 1049, 296-298, P.A.C. From 1840-65 see the Journals of the Legislative Assembly of the Province of Canada, except for 1854 and 1862-64 which were not published. For 1866 see the Sessional Papers of Canada.

11. P.A.C., RG13 C3 Vol. 1049, Minutes, October 15, 1836; M.S.I.C., Minutes, October 18, 1841, February 25, 1842, October 9, 1856; M.S.I.C., Inspectors' Letter Book, Wolfred Nelson and Andrew Dickson to E.A. Meredith, October 2, 1856, "Estimated Sum Required for the Support of the Penitentiary", February 1856.

12. P.A.C., RG13 C3 Vol. 1049, Minutes, July 8, 1837; Reports of the Commissioners appointed to Inquire into the Conduct, Discipline and Management of the Provincial Penitentiary at Kingston, with the documents transmitted by the Commissioners, printed by Order of the Legislative Assembly, (Montreal: Rollo Campbell, 1849), 6 (hereafter cited as Report).

13. Annual Reports of the Prison Discipline Society, Boston. Originally Published 1826-1854, 6 vols. (Montclair, New Jersey: Patterson Smith, 1972), 2:624.

14. M.S.I.C., Convict Liberation Book, Vol. 1, Convict #233, June 1, 1840; Report, 263-64.

15. William Christopher George Norman, "A Chapter of Canadian Penal History: The Early Years of the Provincial Penitentiary at Kingston and the Commission of Inquiry into its Management, 1835-1851", (M.A. thesis, Queen's University, 1979), 18.

16. P.A.C., RG13 C3 Vol. 1049, Minutes, October 15, 1836; Until 1840 the duty of making the daily report of convicts on the Sick List was made by the Keeper of the Kitchen, M.S.I.C., Minutes, April 7, 1840. Also notable is that after 1851 the Hospital Keeper was reclassified as the Hospital Overseer. Ibid., February 6, 1852.

17. P.A.C., RG13 C3 Vol. 1049, Minutes, October 15, 1836.

18. M.S.I.C., August 9, 1847, June 7, 1849, February 23, 1854; Report, 264.

19. M.S.I.C., Minutes, June 7, 1849; Report, 291.

20. M.S.I.C., Minutes, February 23, 1854.

21. Canadian Magazine, November 1895, 8.

22. Report, 264.

23. P.A.C., RG13 C3 Vol. 1049, Minutes, "Report of the Penitentiary Inspectors, 1836", Surgeon's report, October 1, 1836 (hereafter cited as "Report, 1836").

24. P.A.C., RG13 C3 Vol. 1049, Minutes, "Report of the Penitentiary Inspectors, 1837", Surgeon's report, October 1, 1837.

25. "Report, 1836", Surgeon's report.

26. "Annual Report of the Board of Inspectors, 1841", J.L.A., (4 and 5 Victoria, 1st Parl., 1st Sess.), Appendix M., Inspector's report.

27. M.S.I.C., Convict Liberation Book, Vol. 2, reply of J.H., September 8, 1846.

28. Ibid., Vol. 1, reply of convict #44, September 13, 1837.

29. Ibid., Vol. 3, reply of G.F., November 5, 1852.

30. Report, 258.

31. Ibid., 262-63.

32. Ibid., 263-64.

33. M.S.I.C., Convict Liberation Book, Vol. 1, reply of convict #328, May 1, 1841.

34. Ibid., Vol. 2, reply of F.M., October 8, 1846.

35. Ibid., reply of E.C., August 19, 1847.

36. Ibid., Vol. 3, reply of J.D., November 1, 1851.

37. Ibid., reply of J.K., April 4, 1851.

38. Ibid., Vol. 4, reply of B.H., May 11, 1855.

39. Ibid., reply of S.S., November 18, 1856.

40. Ibid., Vol. 3, reply of G.W., September 11, 1850.

41. Report, 268-73; Report, 1849, Surgeon's report.

42. M.S.I.C., Warden's Daily Journal, February 26, 1855; M.S.I.C., Minutes, June 19, 1855, July 30, 1856, September 16, 1859.

43. Margaret Angus, "Dickson, James Robinson", in Dictionary of Canadian Biography. Vol. 11 (1881-1890), (Toronto: University of Toronto Press, 1982), 263; Fifth Annual Report of the Directors of Penitentiaries of the Dominion of Canada for the year 1872; (Canada: Sessional Papers, No. 75, 1873), 13.

44. M.S.I.C., Warden's Daily Journal, July 23, 1850, April 28, 1854.

45. M.S.I.C., Minutes, November 22, 1852.

46. M.S.I.C., Warden's Daily Journal, November 11, 1855;
M.S.I.C., Minutes, November 13, 1855.

47. At the time of the convict's death there was no notice taken of any unusual circumstance Surrounding it, according to the Warden's Daily Journal or the Minutes of the Inspectors; "Penitentiary report for the year 1857", J.L.A., (20 Victoria, 5th Parl., 3rd Sess.), Appendix No. 7, Surgeon's report.

48. M.S.I.C., Minutes, July 30, 1857.

49. Ibid.

50. Ibid., August 1, 1857.

51. For an example of government employment for doctors working to the detriment of their professional reputations, see Beverly A. Smith, "Irish Prison Doctors: Men in the Middle, 1865-1890", Medical History 26 (1982): 371-94. Controversy erupted here over doctors exempting political prisoners from prison regulations.

52. See chapter five of the first part of this report.

Notes to Part One, Chapter Three

1. Report of the Inspector for the Fiscal Year 1897-98. (Canada: Sessional Papers, No. 18, 1899), xiv; Report of the Royal Commission on Penitentiaries. (Ottawa, 1914), 7.

2. C.J. Taylor, "The Kingston, Ontario Penitentiary and Moral Architecture", Histoire Sociale/Social History 12 (1979): 385.

3. It is worth noting that the permanent Provincial Lunatic Asylum was also characterized by deficient systems of heating and ventilation. While its architect John Howard, like William Powers, was unique and innovative in this area, these problems plagued the institution throughout the rest of the century. Tom Brown, "Architecture as Therapy", Archivaria, no. 10 (1980): 117-121.

4. Taylor, "The Kingston, Ontario Penitentiary", 385-87, 392-93, 393. Susanna Moodie, whose travel accounts of early nineteenth-century Ontario are Canadian literary classics, visited the penitentiary at some point in the mid-1840's. She reported that, "The cells are narrow, just wide enough to contain a small bed, a stool, and a wash bowl, and the prisoners are divided from each other by thick stone walls. They are locked in every night at six o'clock, and, their cell is so constructed that one of the Keepers can always look in upon the convict without his being aware of the scrutiny." Susanna Moodie, Life in the Clearings versus Life in the Bush. (New York: DeWitt and Davenport, 1854 [?]), 198.

5. Taylor, "The Kingston, Ontario Penitentiary", 392-93.

6. Reports of the Commissioners appointed to Inquire into the Conduct, Discipline and Management of the Provincial Penitentiary at Kingston, with the documents transmitted by the Commissioners...(Montreal, Rollo Campbell, 1849), 297 (hereafter cited as Report).

7. W. David Lewis, From Newgate to Dannemora: The Rise of the Penitentiary in New York, 1796-1848. (Ithaca, N.Y.: Cornell University Press, 1965), 124-26; Fifth Annual Report of the Board of Inspectors of Asylums, Prisons, etc., for the year 1865. (Province of Canada: Sessional Papers, No. 6, 1866), 84a-84e (hereafter cited as Report, 1865).

8. See, e.g., Museum of the Staff Induction Centre, Correctional Service of Canada, Kingston, Ontario (hereafter cited as M.S.I.C.), Hospital Register, case of M.B., 256; In the early nineteenth century efforts to control contagions through public health measures were marked by bitter debates between contagionists and the anitcontagionists. Contagionists argued that infectious diseases were spread by living agents, and they cited the evident contagiousness of smallpox, measles, and syphilis. Yet this camp had trouble explaining the transmission of other disease today recognized as infectious. The origin, for example, of many cases of scarlet fever, pneumoria, and diptheria was unclear since it was not known that healthy carriers could convey these diseases to susceptible persons. The role of mosquitoes as disease transmitters was also unknown. Consequently, in the search for an answer which would fit all the known facts, most doctors by

the mid-nineteenth century adopted the miasmatic theory. Even though wrong in its basic principle, public health measures based on this theory were successful while contagionist solutions such as isolation and quarantine often failed. The reason for the success of the former theory was that measures predicated on it meant the removal of refuse, garbage, and offal from the streets as well as the draining of marshes and stagnant pools. These expedients thus eliminated the places where bacteria grew or flies and mosquitoes bred. Harry F. Dowling, Fighting Infection: Conquests of the Twentieth Century. (Cambridge, Massachusetts: Harvard University Press, 1977), 7.

9. See, e.g., M.S.I.C., Convict Liberation Book, Vol. 1, reply of convict #184, August 10, 1839; Ibid., Vol. 3, reply of E.N., October 29, 1850.

10. Roger Caron, Go-Boy! (Don Mills: Thomas Nelson & Sons, 1979), 131.

11. "An Act to provide for the Maintenance and Government of the Provincial Penitentiary, erected near Kingston, in the Midland District", Statutes of Upper Canada, 1834, Cap. 37, sec. 27; Besides the periodic problems experienced in obtaining edible provisions from the local contractors who supplied the penitentiary, during the mid-1840s the prison dietary worsened to a near-starvation level due to corruption at the institution. Notably, cases of scurvy appeared there in 1859 and may as well have occured in 1852, when a mysterious disease termed "echymosis" then broke out. Charles Kyle Jolliffe, "An Examination of Medical Services at the Kingston Penitentiary, 1835-1856", (M.A. thesis, Queen's University, 1983), 57-62.

12. "Diet Table of Convicts at the Provincial Penitentiary", dated October 1, 1836. Although unsigned, the writing is unquestionably Sampson's. The table is an exhibit at the Museum of the Staff Induction Centre.

13. "Report of the Commissioners appointed by an Act of the last session of the Provincial Legislature, for the purpose of obtaining Plans and Estimates of a Penitentiary to be erected in this Province", Journals of the House of Assembly of Upper Canada, 1832-33, Appendix, 29.

14. See, e.g., "Report of the Inspectors of the Provincial Penitentiary for 1853", Journals of the Legislative Assemby of the Province of Canada, (18 Victoria, 5th Parl., 1st. Sess.), Appendix D.D., Inspectors' report (hereafter cited as Report, 1853).

15. "Penitentiary report for the year 1856", J.L.A., (20 Victoria, 5th Parl., 3rd Sess.), Appendix No. 7, Surgeon's report.

16. See, e.g., "Statement of the Accounts and Affairs of the Provincial Penitentiary, for the year 1846...", J.L.A., (11 Victoria, 2nd Parl., 3rd Sess.), Appendix N., Inspectors' report (hereafter cited as Report, 1846). For a similar American comment, see Annual reports of the Prison Discipline Society, Boston. Originally Published 1826-1854, 6 vols. (Montclair, New Jersey: Patterson Smith, 1972), 6:736.

17. M.S.I.C., Inspectors' Letter Book, Petition of Wolfred Nelson and Andrew Dickson to Governor-General Edward Walker Head, May 12, 1855.

18. James Edmund Jones, Pioneer Crimes and Punishments in Toronto and the Home District. (Toronto: George N. Morang, 1924), 49-55, 57-68, 70-71, 74-75; Rainer Baehre, "Origins of the Penitentiary System in Upper Canada", Ontario History, 69 (1977): 188; Richard B. Splane, Social Welfare in Ontario, 1791-1893. (Toronto: University of Toronto Press, 1965), 126-27, 154-57.

19. M.S.I.C., "Register of Deaths in Hospital Commencing 1836", in Register of Hospital Cases Commencing 1846.

20. It is difficult to tell how extensive this practice actually was, as these pardons on medical grounds were not recorded as such in the lists of pardons in the annual reports of the penitentiary. Nonetheless, from an examination of the internal prison records between 1836 and 1856 it is clear that there were at least twelve such cases, of which for at least four convicts this expression of clemency came too late for them to be liberated from the prison. See Jolliffe, "An Examination of Medical Services at the Kingston Penitentiary, 1835-1856", 71-76.

21. M.S.I.C., "Register of Deaths in Hospital Commencing 1836", in Register of Hospital Cases Commencing 1846.

22. See, e.g., the case of C.K., who survived a fall from the fifth gallery of a cell block to the ground floor. M.S.I.C., Warden's Daily Journal, April 9-10, 1855; The above accident led the prison authorities to consider a plan for preventing such mishaps. Ibid., April 20, 1855.

23. Ibid., January 29, 1851.

24. Ibid., August 7, 1850, February 19, February 21, May 13, 1856.

25. "Provincial Penitentiary; Statement of Affairs of the Provincial Penitentiary for the year ending September 30, 1851,...", J.L.A., (16 Victoria, 4th Parl., 1st. Sess.), Appendix I.I.I., Warden's report (hereafter cited as Report, 1851).

26. M.S.I.C., "Register of Deaths in Hospital Commencing 1836", in Register of Hospital Cases Commencing 1846.

27. This summary of various health problems at the prison is derived from an analysis of the types of cases treated by the prison doctor during the pre-Confederation era.

28. "Report of the Select Committee on expediency of erecting a penitentiary", Journals of the House of Assembly of Upper Canada, 1831, Appendix, 32-33 (hereafter cited as Report, 1831); Taylor, "The Kingston, Ontario Penitentiary", 387-89; Powers later became the superintending architect and the deputy warden of the penitentiary, positions which he held from 1835 until his controversial dismissal in 1840. For an examination of this event, see William Christopher George Norman, "A Chapter of Canadian Penal History: The Early Years of the Provincial Penitentiary at Kingston and the Commission of Inquiry into its Management, 1835-1851", (M.A. thesis, Queen's University, 1979), 30-34.

29. Report, 1831, 37.

30. Ibid, 37-38.

31. Public Archives of Canada (hereafter cited as P.A.C.), RG13 C3 Vol.1049, Minutes of the Board of Inspectors of the Provincial Penitentiary, "Report of the Inspectors of the Provincial Penitentiary, 1836", Surgeon's report, October 1, 1836; "The annual report of the Inspectors of the Provincial Penitentiary, for the year 1855", (19 Victoria, 5th Parl., 2nd Sess.), Appendix No. 10, Surgeon's report; Norman, "A Chapter of Canadian Penal History", 29n.

32. Report, 136.

33. P.A.C., RG13 C3 Vol. 1049, Minutes, July 8, 1837.

34. See the inventories of prison property in the annual reports of the institution for 1836-1848. Valuations of these items are listed here, but the figures may be inflated. See Norman, "A Chapter of Canadian Penal History", 160.

35. M.S.I.C., Convict Liberation Book, Vol. 1, reply of L.P.H., May 30, 1844.

36. Ibid., Vol. 2, reply of A.H.M., June 30, 1848.

37. See, e.g., the case of J.C., M.S.I.C., Hospital Register, 167.

38. Report, 1846, Surgeon's report.

39. M.S.I.C., Warden's Letter Book, H. Smith to the Penitentiary Inspectors, May 18, 1837.

40. Ibid.

41. Ibid.

42. Norman, "A Chapter of Canadian Penal History", 23n.51.

43. "Annual Report of the Board of Inspectors, 1841", J.L.A., (4 and 5 Victoria, 1st Parl., 1st Sess.), Appendix M., Surgeon's report.

44. M.S.I.C., Minutes, January 13, February 25, 1842.

45. Ibid., July 27, 1844, November 1, 1845.

46. "Statement of the Accounts and Affairs of the Provincial Penitentiary, for the year 1844...", J.L.A., (9 Victoria, 2nd Parl., 3rd. Sess.), Appendix G., Surgeon's report; Report, 1846, Surgeon's report.

47. Report, 1846, Inspectors' report.

48. Splane, Social Welfare in Ontario, 137.

49. Norman, "A Chapter of Canadian Penal History", 151-60.

50. "Provincial Penitentiary, Annual Accounts, for 1849", J.L.A. (14 Victoria, 1850), Appendix R.R., Inspectors' report (hereafter cited as Report, 1849).

51. Ibid., Surgeon's report.

52. M.S.I.C., Minutes, September 25, 1850, November 18, 1853.

53. Report, 1849, Surgeon's report; Report, 1851, Surgeon's report; M.S.I.C., Minutes, August 29, 1854.

54. Report, 1853, Inspectors' report.

55. Taylor, "The Kingston, Ontario Penitentiary", 393.

56. Report, 1853, Inspectors' report.

57. Report of the Board of Inspectors of Asylums, Prisons, etc., for the year 1863. (Province of Canada, Sessional Papers, No. 39, 1864), Pt.3, Provincial Penitentiary; Report, 1865, 84h.

58. John Campbell, Thirty Years' Experience of a Medical Officer in the English Convict Service. (London: T. Nelson and Sons, 1884), 46-64.

59. J.J. Heagerty, Four Centuries of the Medical History of Canada, 2 vols. (Toronto: Macmillan, 1928), 2: Part 6 (142-290).

60. Margaret Angus, "Sampson, James", in Dictionary of Canadian Biography. Vol. 9, (1861-1870), (Toronto: University of Toronto Press, 1976), 700.

Notes to Part One, Chapter Four

1. "An Act to provide for the Maintenance and Government of the Provincial Penitentiary, erected near Kingston, in the Midland District", Statutes of Upper Canada, 1834, Cap. 37, sec. 36.

2. H.W. Kipp, "Chronolgic Report of One Hundred Twenty-Five Years Service of the Sing Sing Prison Hospital", New York State Journal of Medicine, November 1, 1957, 3516; "Report of the Commissioners appointed by an Act of the last session of the Provincial Legislature, for the purpose of obtaining Plans and Estimates of a Penitentiary to be erected in this Province", Journals of the House of Assembly of Upper Canada, Appendix, 1832-33, 34-35; Charles E. Rosenberg, "The Cause of Cholera: Aspects of Etiological Thought in 19th Century America", in Judith Walzer Leavitt and Ronald L. Numbers, eds., Sickness & Health in America. (Madison, Wisconsin: The University of Wisconsin Press, 1978), 257-250.

3. Annual Reports of the Prison Discipline Society, Boston. Originally Published 1826-1854, 6 vols. (Montclair, New Jersey: Patterson Smith, 1972), 2:659-60, 726-730.

4. Geoffrey Bilson, A Darkened House: Cholera in Nineteenth-Century Canada. (Toronto: University of Toronto Press, 1980), 79.

5. Public Archives of Canada (hereafter cited as P.A.C.), RG13 C3 Vol. 1049, Minutes of the Board of Inspectors of the Provincial Penitentiary, July 27, 1837; Ibid., "Report of the Penitentiary Inspectors, 1837", Surgeon's report, October 1, 1837.

6. Museum of the Staff Induction Centre, Correctional Service of Canada, Kingston, Ontario (hereafter cited as M.S.I.C.), Minutes of the Board of Inspectors of the Provincial Penitentiary, January 18, 1847.

7. Ibid., May 7, 1856.

8. "Provincial Penitentiary, Annual Accounts, for 1849", Journals of the Legislative Assembly of the Province of Canada, (14 Victoria, 1850), Appendix R.R., Surgeon's report (hereafter cited as Report, 1849).

9. Maxwell M. Wintrobe, ed. et. al., Harrison's Principles of Internal Medicine. 7th ed., 2 vols. (New York: McGraw Hill, 1974), 1:782.

10. See the Surgeon's reports for 1837, 1842, 1844, and 1846-48.

11. M.S.I.C., Hospital Register, case of A.C., 243.

12. Report, 1849, Surgeon's report.

13. Wintrobe, Harrison's Principles, 1:779.

14. M.S.I.C., Hospital Register, case of H.B., 251.

15. Report, 1849, Surgeon's report.

16. Bilson, A Darkened House, 126.

17. M.S.I.C., Hospital Register, case of H.B., 251.

18. M.S.I.C., Minutes, June 7, 1849.

19. P.A.C., RG73 Vol. 4, File 1-2-11, "Rules and Regulations Governing Medical Care and Treatment for Convicts Penitentiary Regulations, 1933", section 317; Rules and Regulations for the Government of the Penitentiaries of the Dominion of Canada. (Ottawa, 1870), 16; The Penitentiary Acts and the Rules and Regulations for the Government of the Penitentiaries of Canada. (Ottawa, 1888), 9; Penitentiary Regulations Canada 1899. (Ottawa, 1899), 11.

20. M.S.I.C., Hospital Register, case of T.B., 256.

21. Report, 1849, Surgeon's report.

22. Bilson, A Darkened House, 127.

23. It should be pointed out that both, Dr. Sampson and Dr. Dickson, like many other physicians of their time, viewed asiatic cholera as only an aggravated form of the common cholera, also known as cholera morbus. This was a versatile term used to describe ailments as dissimilar as dysentery and diarrhea. As Charles Rosenberg has noted, this terminology made the epidemic less fearsome because it did not appear as a wholly new disease, but only as a worse form of an ailment already encountered. As well this nomenclature implied a local orgin for the disease, thus ruling out its importation and contagionism. Rosenberg, "The Cause of Cholera", 258. Cholera morbus occurred periodically at the penitentiary in the pre-Confederation era, most notably in 1845 with twenty-two cases being recorded and again in 1865 when thirty-one cases were registered. See the Surgeon's reports for the years 1836-1866.

24. Report, 1849, Surgeon's report.

25. Robert J. Morris, Cholera 1832 The Social Response to an Epidemic. (London: Croon Helm, 1976), 163.

26. Charles Rosenberg, "The Therapeutic Revolution: Medicine, Meaning and Social Change in Nineteenth-Century America", in M.J. Vogel and C.E. Rosenberg, eds., The Therapeutic Revolution. (Philadelphia: University of Pennsylvania Press, 1979), 5-9.

27. Norman Howard-Jones, "Cholera Therapy in the Nineteenth Century", Journal of the History of Medicine, 27 (1972): 373.

28. Ibid.

29. M.S.I.C., Hospital Register, case of J.D., 252, case of A.I., 255; Howard-Jones, "Cholera Therapy", 374-75.

30. M.S.I.C., Hospital Register, case of M.W., 259, case of J.B.N. 260, case of A.C., 261, case of J.E., 262.

31. J.S. Haller, American Medicine in Transition 1840-1860. (Chicago: University of Illinois Press, 1981). 77-78.

32. M.S.I.C., Hospital Register, Case of J.H., 257, Case of P.S., 258; Howard-Jones, "Cholera Therapy", 380; Bilson, A Darkened House, 163.

33. Report, 1849, Surgeon's report; Bilson, A Darkened House, 163.

34. Report, 1849, Surgeon's report.

35. Ibid.

36. M.S.I.C., Hospital Register, case of W.J., 252.

37. Report, 1849, Inspectors' report.

38. Ibid., Surgeon's report.

39. It is worth noting that on July 30th the Kingston British Whig had reported about how the Ohio Penitentiary was being ravaged by cholera.

40. Reports of the Prison Discipline Society, 5:481-85.

41. Ibid., 5:533-35.

42. David J. Rothman, The Discovery of the Asylum. (Boston: Little, Brown and Company, 1971), 100.

43. M.S.I.C., Hospital Register, case of J.P., 310.

44. "Penitentiary report for the year 1856", J.L.A., (20 Victoria, 5th Parl., 3rd Session), Appendix No. 7, Inspectors' report; Fifth Annual Report of the Board of Inspectors of Asylums, Prisons, etc. for the year 1865. (Province of Canada, Sessional Papers, No. 6, 1866), 84g-84h. (hereafter cited as Report, 1865).

45. M.S.I.C., Sick List Diary, July-September 1854; M.S.I.C., "Register of Deaths in Hospital Commencing 1836", in Register of Hospital Cases Commencing 1846.

46. "Provincial Penitentiary: Statement of the Affairs of the Provincial Penitentiary for the year ending 30 September 1851...", J.L.A., (16 Victoria, 4th Parl., 1st Sess.), Appendix I.I.I., Surgeon's report.

47. Bilson, A Darkened House, 132.

48. M.S.I.C., Minutes, June 27, 1854.

49. M.S.I.C., Sick List Diary, July-September 1854.

50. M.S.I.C., Warden's Daily Journal, July 21, 1854; For an examination of the practice of contract labour at the penitentiary, see H. Clare Pentland, Labour and Capital in Canada 1650-1850. (Toronto: James Lorimer & Company, 1981), 14-21.

51. M.S.I.C., Warden's Daily Journal, July 21, 1854.

52. Ibid., July 28, 1854.

53. M.S.I.C., Inspectors' Letter Book, "Report of the Penitentiary Inspectors, for 1854", February 12, 1855.

54. See, e.g. the case of J.L., M.S.I.C., Hospital Register, 308.

55. Report, 1865, 84a; Sixth Annual Report of the Board of Inspectors of Prisons, Asylums, etc., for the Year 1866. (Canada: Sessional Papers, No. 40, 1867-68), 158 (hereafter cited as Report, 1866); Bilson, A Darkened House, 137.

56. M.S.I.C., "Register of Deaths in Hospital Commencing 1836", in Register of Hospital Cases Commencing 1846; Report, 1865, 84h.

57. Fourth Annual Report of the Board of Inspectors of Prisons, Asylums, etc., for the Year 1864. (Province of Canada: Sessional Papers, No. 14, 1865), Provincial Penitentiary, Warden's report; Report, 1865, 84g.

58. Report of the Board of Inspectors of Prisons, Asylums, etc., for the Year 1863. (Province of Canada, Sessional Papers, No. 39, 1864), Provincial Penitentiary, Warden's report; Report, 1866, 4.

59. Third Annual Report of the Board of Inspectors of Prisons, Asylums, etc. for the Year 1862. (Province of Canada: Sessional Papers, No. 66, 1863), Report of Inspector Ferres (hereafter cited as Report, 1862).

60. Report, 1865, 84g.

61. Report of the Commissioners Appointed to Inquire into the State of Affairs at the Kingston Penitentiary. (Ottawa, 1897), 20-21.

62. Report, 1862, Provincial Penitentiary, Warden's report.

Notes to Part One, Chapter Five

1. T.E. Brown, "Living with God's Afflicted: A History of the Provincial Lunatic Asylum at Toronto, 1830-1911", (Ph.D. thesis, Queen's University, 1981), 51-55; David Rothman, The Discovery of the Asylum. (Boston: Little, Brown and Company, 1971), 130, 271-74.

2. Annual Reports of the Prison Discipline Society, Boston. Originally Published 1826-1854, 6 vols. (Montclair, New Jersey: Patterson Smith, 1972), 1:66-68.

3. Museum of the Staff Induction Centre, Correctional Service of Canada, Kingston, Ontario (hereafter cited as M.S.I.C.), Warden's Letter Book, H. Smith to James Nickalls, April 21, 1838; Ibid., H. Smith to T.D. Harrington, February 8, 1843.

4. Reports of the Prison Discipline Society, 3:404-05.

5. Rothman, The Discovery of the Asylum, 87-88; Negley Teeters, an American historian, has concluded after careful study that Louis Dwight, the arch supporter of the congregate system, failed to prove that prisons run under the separate system bred insanity among prisoners. Blake McKelvey, American Prisons A History of Good Intentions. (Montclair, New Jersey: Patterson Smith, 1977), 29.

6. Rothman, The Discovery of the Asylum, 79-108.

7. M.S.I.C., Minutes of the Board of Inspectors of the Provincial Penitentiary, February 19, July 18, 1846.

8. M.S.I.C., Warden's letter Book, H. Smith to T.D. Harrington, February 8, 1843.

9. Reports of the Prison Discipline Society, 3:185.

10. M.S.I.C., Hospital Register, case of J.C., 167; M.S.I.C., Inspectors' Letter Book, "Report of the Provincial Penitentiary for 1854", February 12, 1855; "Penitentiary report for the year 1856", Journals of the Legislative Assembly of the Province of Canada, (20 Victoria, 5th Parl., 3rd Sess.), Appendix No. 7, Inspectors' report (hereafter cited as Report, 1856); M.S.I.C., Minutes, March 13, November 10, 1856.

11. Reports of the Commissioners appointed to Inquire into the Conduct, Discipline, and Management of the Provincial Penitentiary at Kingston; with the documents transmitted by the Commissioners...(Montreal: Rollo Campbell, 1849), 195-208 (hereafter cited as Report).

12. W. David Lewis, From Newgate to Dannemora: The Rise of the Penitentiary in New York. (Ithaca, N.Y.: Cornell University Press, 1965), 98-99.

13. M.S.I.C., Minutes, June 30, August, October 8, 1847; Report, 194, 330.

14. See, e.g., the Convict Liberation Book, for 1846, at the M.S.I.C., Fifteen of the fifty-four convicts released that year reported that punishment there had been cruel and/or injurious to their health.

15. Lewis, From Newgate to Dannemora, 98; Report, 183-84; Susanna Moodie, Life in the Clearings versus Life in the Bush. (New York: DeWitt & Davenport, 1854 [?]), 168.

16. "Provincial Penitentiary, Annual Accounts for 1849", Journals of the Legislative Assembly of the Province of Canada, (14 Victoria, 1850), Appendix R.R., Warden's report (hereafter cited as Report, 1849).

17. Report, 198-200.

18. Ibid., 200.

19. Ibid., 315-30.

20. Ibid., 325.

21. Ibid., 198.

22. Ibid.

23. Ibid., 196-98.

24. M.S.I.C., Convict Liberation Book, Vol. 1, reply of convict D., August 8, 1841, reply of convict D., September 8, 1841, reply of T.D., October 11, 1845, Vol. 2, reply of E.C., July 19, 1847, reply of P.O., October 6, 1849.

25. Report, 196.

26. Ibid., 197-98.

27. Ibid., 28, 196.

28. Ibid., 203-04, 320.

29. M.S.I.C., Minutes, April 5, 1847.

30. Report, 320.

31. Ibid., 204; M.S.I.C., Hospital Register, 158.

32. Roger Smith, Trial by Medicine. (Edinburgh: Edinburgh University Press, 1981), 38.

33. Ibid.

34. Report, 204.

35. J.M.S. Careless, Brown of the Globe, vol. 1. (Toronto: Macmillan, 1959), 79-80.

36. Ibid., 78-79.

37. William George Christopher Norman, "A Chapter of Canadian Penal History: The Early Years of the Provincial Penitentiary at Kingston and The Commission of Inquiry into its Management, 1835-1851", (M.A. thesis, Queen's University, 1979), 69-77.

38. Report, 16-25.

39. Ibid., 20.

40. Norman, "A Chapter of Canadian Penal History", 111-16.

41. Ibid., 69.

42. Report, 32-35.

43. Ibid., 34-35.

44. Ibid., 35.

45. Ibid., 321-22.

46. Ibid., 258-73.

47. Ibid., 268-71, 273.

48. Ibid., 271.

49. Ibid., 324-27.

50. Ibid., 326.

51. Ibid.

52. Ibid., 327.

53. Ibid., 327-28.

54. Ibid.

55. Ibid., 328-30; Understandably, with tempers high at the prison, Dr. Sampson asked the Government to relive him from his post, pending the findings of the Commission of Inquiry. This request was granted and from June 21, 1848 until June 25, 1849, his place was taken by Dr. Horatio Yeates. "Provincial Penitentiary, Annual Accounts, for 1849", J.L.A., (14 Victoria, 1850), Appendix R.R., Inspectors' report, Surgeon's report, (hereafter cited as Report, 1849).

56. Report, 198, 236-39.

57. Ibid., 206-09.

58. Ibid., 288.

59. Ibid., 286-87.

60. Smith, Trial by Medicine, 4.

61. Report, 198.

62. Ibid.

63. See Careless, Brown of the Globe, Vol. 1, 84; J. Alex Edmison, "Some Aspects of Nineteenth-Century Canadian Prisons", in W.T. McGrath, ed., Crime and Its Treatment in Canada Second Edition. (Toronto: Macmillan, 1976), 348; Norman, "A Chapter of Canadian Penal History", 150-51; Sydney Shoom, "Kingston Penitentiary: The Early Decades", Canadian Journal of Corrections 3 (1979): 218-19; William Teatero, "The Tragic Life of William Dill", pt. 2 Kingston Whig-Standard, June 26, 1982, magazine section, 5.

64. P.A.C., RG13 C3, Vol. 1050, Warden's Letter Book, D.AE. Macdonell to James Leslie, November 18, 1850; M.S.I.C., Minutes, December 5, 1850; Earlier that year an intermittently insane male convict was released on the Government's order since it was apparent he could look after himself. P.A.C., RG13 C3, Vol. 1050, Warden's Letter Book, D.AE. Macdonnell to James Leslie, May 3, 1850.

65. P.A.C., RG13 C3, Vol. 1050, Warden's Letter Book, D.AE. Macdonell to James Leslie, March 17, 1851.

66. Report, 1849, Inspectors' report; "Provincial Penitentiary, Annual Accounts for 1850", J.L.A., (15 Victoria, 1851), Appendix W., Inspectors' report.

67. Report, 1849, Surgeon's report.

68. P.A.C., George Brown Papers, "Coroner's Inquest into the Death of J.M.", MG 24 B40 Vol. 25, 4057-4062.

69. M.S.I.C., Minutes, November 11, 1847.

70. "An Act for the better Management of the Provincial Penitentiary", Statutes of the Province of Canada, 1851, Cap. 2, Sec. 46; Norman, "A Chapter of Canadian Penal History", 174; In 1857 the law was amended to enable the Surgeon of the Provincial Penitentiary and the Superintendent of the Criminal Lunatic Asylum to handle this function. Charles Kyle Jolliffe, "An Examination of Medical Services at the Kingston Penitentiary, 1835-1856", (M.A. thesis, Queen's University, 1983), 186-187.

71. P.A.C. RG13 C3, Vol. 1050, Warden's Letter Book, D.AE. Macdonell to E.A. Meredith, November 17, 1851.

72. Statutes of the Province of Canada, 1851, Cap. 2, Sec. 46.

73. P.A.C., RG13 C3, Vol. 1050, Warden's Letter Book, D.AE. Macdonell to John Scott, Medical Superintendent, Lunatic Asylum, November 29, 1851.

Notes to Part One, Chapter Six

1. This new practice was a reflection of the recognition by Canadian courts of the so-called M'Naghten rules. These had been set down in 1843 by the English House of Lords as the definitive statement of the legal principles regarding the application of the defence of insanity in a criminal trial. Understandably, in 1851 the Legislature of the Province of Canada passed an Act "to authorize the confinement of lunatics in cases where there (sic) being at large may be dangerous to the public". It contained statutory provisions concerning insanity acquittals. And, not surprisingly, this Act was based on the "Criminal Lunatics Act" passed in England in 1800. Simon N. Verdun-Jones and Russell Smnandych, "Catch-22 in the Nineteenth Century: The Evolution of Therapeutic Confinement for the Criminally Insane in Canada, 1840-1900", Criminal Justice History, 2 (1981): 85-89."

2. "Report of the Inspectors of the Provincial Penitentiary, for 1853", Journals of the Legislative Assembly of the Province of Canada, (18 Victoria, 5th Parl., 1st Sess.), Appendix D.D., Surgeon's report (hereafter cited as Report, 1853); P.A.C., RG13 C3 Vol. 1050, Warden's Letter Book, D.AE. Macdonell to James Leslie, November 24, December 7, 1848.

3. Report, 1853, Surgeon's report; Museum of the Staff Induction Centre, Correctional Service of Canada, Kingston, Ontario (hereafter cited as M.S.I.C.), Warden's Daily Journal, October 25, 1851.

4. Report, 1853, Surgeon's report; P.A.C., RG13 C3 Vol. 1050, Warden's Letterbook, D.AE. Macdonell to the Medical Superintendent, Lunatic Asylum, July 6, 1853.

5. M.S.I.C., Minutes of the Board of Inspectors of the Provincial Penitentiary, December 20, 1851, July 6, 1853; Report, 1853, Surgeon's report; P.A.C., RG13 C3 Vol. 1050, Warden's Letter Book, D.AE. Macdonell to the Medical Superintendent, Lunatic Asylum, August 16, 1853.

6. P.A.C., RG13 C3 Vol. 1050, Warden's Letterbook, "A Return for the information of His Excellency the Governor-General of Convicts now in the temporary Lunatic Asylum within the Provincial Penitentiary...", July 19, 1856.

7. P.A.C., RG5 C1 Vol. 398, Dossier #1647, Joseph Workman to A.N. Morin, July 30, 1853. Workman included with this letter certificates from two physicians attesting to the sanity of each convict.

8. Ibid.

9. P.A.C., RG5 C1 Vol. 398, Dossier #1345, Joseph Workman to P.J.O. Chaveau, September 10, 1853.

10. Ibid.

11. Ibid.

12. T.E. Brown, "Living with God's Afflicted: A History of the Provincial Lunatic Asylum at Toronto, 1830-1911", (Ph.D. thesis, Queen's University, 1981), 182.

13. Gerald Grob, Mental Institutions in America: Social Policy up to 1875. (New York: Free Press, 1973), 189.

14. P.A.C., RG4 C1 vol. 339, Dossier #1756, D.AE. Macdonell to P.J.O. Chaveau, September 9, 1853.

15. See page 81, infra; P.A.C., RG4 C1 Vol. 339, Dossier #1756, G.E. Cartier to D.AE. Macdonell, March 19, 1855.

16. P.A.C., RG5 C1 Vol. 398, Dossier #1345, P.J.O. Chaveau to Warden, Provincial Penitentiary, September 17, 1853.

17. Ibid., Dossier #1647, Wolfred Nelson and Andrew Dickson to P.J.O. Chaveau, with "a petition to his Excellency the Administrator of the Government", November 17, 1853.

18. According to the Minutes of the Penitentiary Inspectors, no insane convicts were transferred to the Provincial Lunatic Asylum at Toronto after July 1853.

19. Report, 1853, Inspectors' report.

20. Ibid., Surgeon's report.

21. M.S.I.C., Inspectors' Letter Book, "Report of the Penitentiary Inspectors, for 1854", February 12, 1855.

22. J.A. Macdonald to Provincial Secretary, February 27, 1855, in J.K. Johnson, ed., The Letters of John A. Macdonald, 2 vols. (Ottawa: Public Archives of Canada, 1969), 1:249 (hereafter cited as Letters), quoted by Catherine A. Sims, "An Institutional History of the Asylum for the Insane at Kingston, 1856-1885", (M.A. thesis, Queen's University, 1981), 13.

23. Macdonald had considered that the duties of the asylum superintendent were too demanding to be assumed by the penitentiary doctor. He believed that besides the fact Dr. Sampson was not particularly qualified for the post, his usual duties at the prison would not allow him enough time to give proper treatment to lunatics there. Letters, 1:249.
The best biography of Dr. Litchfield is by A.W. Rasporich and I.H. Clarke, in the Dictionary of Canadian Biography. Vol. 9 (1861-1870), (Toronto: University of Toronto Press, 1976), 470-71. For a list of others, see Sims, "An Institutional History", 17n.13.

24. Letters, 1:249-50.

25. M.S.I.C., Minutes, March 13, 1855; P.A.C., RG13 C3 Vol. 1050, Warden's Letter Book, D.AE. Macdonell to G.E. Cartier, March 9, 1855, D.AE. Macdonell to Dr. Litchfield, April 22, 1855.

26. M.S.I.C., Warden's Daily Journal, June 27, 1855.

27. Ibid., May 8, May 22, 1855; Sims, "An Institutional History", 12.

28. "The annual report of the Inspectors of the Provincial Penitentiary, for the year 1855", J.L.A., (19 Victoria, 5th Parl., 2nd Sess.), Appendix No. 10, Surgeon's report.

29. Ibid., Inspectors' report.

30. "Penitentiary report for the year 1856", J.L.A. (20 Victoria, 5th Parl., 3rd. Sess.), Appendix No. 7 Inspectors' report (hereafter cited as Report, 1856).

31. Rothman, The Discovery of the Asylum, 242-43.

32. M.S.I.C., Warden's Daily Journal, July 16, 1855.

33. M.S.I.C., Minutes, November 4, November 10, 1856; M.S.I.C., Warden's Daily Journal, November 4-12, 1856; Richard B. Splane, Social Welfare in Ontario 1791-1893. (Toronto: University of Toronto Press, 1965), 137.

34. Sims, "An Institutional History", 12.

35. Report, 1856, Inspectors' report.

36. Ibid.

37. Ibid.

38. "Provincial Penitentiary report for the year 1857", J.L.A., (21 Victoria, 6th Parl., 1st. Sess.), Appendix No. 11, Warden's report.

39. Letters, 2:86n.1.

40. Third Annual Report of the Board of Inspectors of Prisons, Asylums, etc., for the Year 1862. (Province of Canada, Sessional Papers, No. 39, 1864), 3, 7.

41. M.S.I.C., Minutes, December 30, 1858.

42. "Annual report of the Provincial Penitentiary for the year 1858", J.L.A., (22 Victoria, 6th Parl., 2nd Sess.), Appendix No. 29, Warden's report.

43. M.S.I.C., Minutes, February 3, 1859.

44. Ibid., April 5, 1859.

45. Ibid., March 30, 1859.

46. Ibid., April 30, June 15, August 4, 1859; Sims, "An Institutional History", 12.

47. Sims, "An Institutional History", 18-20.

48. Ibid., 20, 44.

49. Rothman, The Discovery of the Asylum, 265-69.

50. E.C. Wines and Theodore W. Dwight, Report on the Prisons and Reformatories of the United States and Canada. (Originally published Albany, N.Y., 1867; reprinted New York: AMS Press, 1971), 248; In the case of New York State, a State Lunatic Asylum for Insane Convicts was opened in 1859 on a site adjacent to the Auburn Penitentiary. Previously, from 1843 to 1859, convicts who became insane were regularly sent to the Utica State Asylum or to special wards in prison buildings. Albert Deutsch, The Mentally Ill in America. (New York: Columbia University Press, 1949), 412.

51. Rothman, The Discovery of the Asylum, 271-72.

52. Smith, Trial by Medicine, 22-23.

53. See, e.g., the case of J.M., who smeared his hospital cell with excrement. M.S.I.C., Warden's Daily Journal, November 7-9, November 12-13, 1856.

54. Ibid., August 26, 1856.

55. See, e.g., the case of convict T., Ibid., September 6, 1856.

56. See, e.g., the case of J.M., Ibid., August 15, 1856.

57. "Report of the Inspectors of the Provincial Penitentiary for 1852", J.L.A., (16 Victoria, 1853), Appendix I.I.I., Warden's report.

58. Rules and Regulations to be Observed by the Officers of the Provincial Penitentiary. (Kingston: James N. Creighton, Printer, 1856), 7.

Notes to Part One, Chapter Seven

1. Andrew T. Scull, "Moral treatment reconsidered: some sociological comments on an episode in the history of British psychiatry", Psychological Medicine 9 (1979): 426-28.

2. Michael Ignatieff, "State, Civil Society, and Total Institutions: A Critique of Recent Social Histories on Punishment", in Michael Tonry and Norval Morris, eds., Crime and Justice 3 (1981): 170.

3. David J. Rothman, The Discovery of the Asylum. (Boston: Little, Brown and Company, 1971), 237-247.

Notes to Part Two

1. Beyond the Walls. (Ottawa: Correctional Service of Canada, Communications Division, 1983), 8.

2. Statutes of Canada, 1868, Cap. 75, sec. 11, 64.

3. First Annual Report of the Board of Directors of Penitentiaries of the Dominion of Canada for the Year 1868. (Canada: Sessional Papers, No. 5, 1870), 14, 44, 53 (hereafter cited as Report, 1868).

4. Return to an Address of the House of Commons, dated March 26, 1868; for the Report of the Prison Inspectors of the late Province of Canada on the Prisons of Nova Scotia and New Brunswick. (Canada, Sessional Papers, No. 40, 1868), 2.

5. Donald Grant Wetherall, "Rehabilitation Programmes in Canadian Penitentiaries, 1867-1914: A Study of Official Opinion", (Ph.d. thesis, Queen's University, 1980), 2.

6. Nineteenth Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year Ended 30 June 1894. (Canada, Sessional Papers, No. 18, 1895), xii-xiv; Gerald Woods and Heather Sim, Highlights of Federal Initiatives in Criminal Justice: 1966-1980. (Ottawa: Ministry of the Solicitor General of Canada, Research Division, 1981), 2.

7. Wetherall, "Rehabilitation Programmes", 1, 4.

8. Rules and Regulations for the Government of the Penitentiaries of the Dominion of Canada. (Ottawa, 1870), (hereafter cited as Penitentiary Regulations, 1870); The Penitentiary Acts and the Rules and Regulations for the Government of the Penitentiaries of Canada. (Ottawa, 1888), (hereafter cited as Penitentiary Regulations, 1888); Penitentiary Regulations Canada 1899. (Ottawa, 1899), (hereafter cited as Penitentiary Regulations, 1899).

9. Wetherall, "Rehabilitation Programmes", 3.

10. Ibid.; Coral Wesley Topping, Canadian Penal Institutions. (Chicago: University of Chicago Press, 1930), 23.

11. Statutes of Canada, 1918, Chap. 36, sec. 1-3.

12. J. Ian Casselman, "The Secret Plague Venereal Disease in Early Twentieth Century Canada", (M.A. thesis, Queen's University, 1981), 366.

13. Public Archives of Canada (hereafter cited as P.A.C.), RG73 Vol. 30, File 1-18-6, "Paper Submitted, by Inspector Stewart, to the Warden's Convention held at Kingston, January 1901", 2.

14. Report of the Commissioners Appointed to Inquire into the Affairs of the Kingston Penitentiary. (Ottawa, 1897), 3 (hereafter cited as Report of the Commissioners).

15. P.A.C., MG26A, Papers of the Rt. Hon. Sir John Alexander Macdonald, Vol 519, J.A. Macdonald to Dr. Lavell, December 19, 1871, Vol. 520, J.A. Macdonald to Rev. G.R. Sanderson, March 16, 1872.

16. Museum of the Staff Induction Centre, Correctional Service of Canada, Kingston, Ontario. (hereafter cited as M.S.I.C.) Minutes of the Inspector of Penitentiaries, September 4, 1885 (hereafter cited as Minutes).

17. Penitentiary Regulations 1899, 24-25.

18. Report of the Inspector of Penitentiaries...for the Year ended 30 June, 1894, xii.

19. Report of the Commissioners, 3-8.

20. Report of the Royal Commission on Penitentiaries. (Ottawa, 1914), 8.

21. Statutes of Canada, 1868, Cap. 75, sec. 62; It is worth noting that this limitation on remission for genuinely ill convicts apparently remained in place until 1938, when it was almost totally lifted. A new regulation stipulated that an ill convict was now to earn only one day less remission per month than the other well-behaved convicts. This change appears to have been a result of the Archambault Royal Commission, whose report, issued in 1938, thoroughly studied the questions of parole and remission. Finally, in 1959, this restriction was lifted completely and every convict hospitalized for one month or move because of illness was able to earn full remission provided they were otherwise so qualified. This step was taken after many complaints that the 1938 regulation was unfair to those affected by it. Moreover, advances in medical techniques and treatments had made the possibility of malingering a distant one. M.S.I.C, Circular No. 66, August 1, 1938, Circular Letter No. 13, October 16, 1959.

22. Ibid., 1906, Chap. 38, sec. 38.

23. Wetherall, "Rehabilitative Programmes", 22.

24. Michael Jackson, Prisoners of Isolation. (Toronto: University of Toronto Press, 1983), 35-39.

25. Wetherall, "Rehabilitative Programmes", 301-02.

26. Ibid., 158-75; W.L. Morton, The Critical Years. (Toronto: McClelland and Stewart Limited, 1964), 277.

27. Wetherall, "Rehabilitative Programmes", 176; Blake McKelvey, American Prisons. (Montclair, New Jersey: Patterson Smith Ltd., 1977), 116-131.

28. Sixteenth Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year Ended 30 June, 1891. (Canada: Sessional Papers, No. 18, 1892), xxi, 7.

29. Wetherall, "Rehabilitative Programmes", 181-93.

30. Canada: House of Commons, Debates, 1914, 4484-85 (May 29).

31. Report of the Royal Commission on Penitentiaries, 6-27, 41-44.

32. Ibid., 26.

33. Canada: House of Commons, Debates, 1915, 1740-42 (March 30).

34. P.A.C., RG73 Vol. 41, File 1-20-10, Pt. 6, "Memorandum for the Deputy Minister", March 15, 1915.

35. Canada: House of Commons, Debates, 1916, 2118-21 (March 24).

36. Wetherall, "Rehabilitative Programmes", 303.

37. Roger Graham, "Through the First World War", in J.M.S. Careless and R. Craig Brown, eds., Part One of the Canadians 1867-1967. (Toronto: Macmillan 1968), 183.

38. Ibid., 190-201.

39. Penitentiary Regulations, 1870, 15-16; Penitentiary Regulations, 1888, 8-9; Penitentiary Regulations, 1899, 10-11.

40. Annual Report of the Inspector of Penitentiaries for the Fiscal Year 1900-01. (Canada, Sessional Papers, No. 34, 1902), 15, 60-61.

41. Thirteenth Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year Ended 30 June 1888. (Canada: Sessional Papers, No. 12, 1889), 111; Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1921. (Canada, Sessional Papers, No. 35, 1922), 27. Interestingly, it was noted here that the new surgeon arrived at the penitentiary at the same daily time as his predecessor, but spent from two to four times as long there as the average visit of the latter. The new surgeon's work was regarded as "very satisfactory," and he was praised for his "carefulness in the matter of avoiding any interference with discipline, which can be avoided without neglect of the patient."

42. Fifth Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year Ended 30 June, 1880. (Canada, Sessional Papers, No. 65, 1881), 16-17.

43. Report of the Commissioners. 27; Canada: House of Commons, Debates, 1897, 4744 (June 21).

44. Statutes of Canada, 1895, Chap. 42, sec. 3.

45. See, e.g., Canada: House of Commons, Debates, 1880, 1019-20 (April 2).

46. Statutes of Canada, 1899, Chap. 48, "Schedule"; Report of the Inspector for the Fiscal Year 1898-99. (Canada: Sessional Papers, No. 18, 1900), 1.

47. Canada: House of Commons, Debates, 1895, 4368-79 (July 15).

48. Minutes, September, 26, 1892.

49. Statutes of Canada, 1895, Chap. 42, sec. 3.

50. Penitentiary Regulations, 1870, 23, 39-40.

51. J. Alex Edmison, "Some Aspects of Nineteenth-Century Canadian Prisons", in W.T. McGrath ed. Crime and Its Treatment in Canada, Second Edition. (Toronto: Macmillan, 1976), 362, 364; Canada: House of Commons, Debates, 1895, 4367-68 (July 15); Statutes of Canada, 1895, Chap. 42, sec. 10.

52. See, e.g., the report of the Warden of the St. Vincent de Paul Penitentiary for the fiscal year 1887-88.

53. For example, it was described in 1895 "as a model of its kind. Here neatness reigns supreme; the waxed floors, spotless walls, and neatly-furnished dispensing-room reflecting great credit on its genial overseer." Canadian Magazine, November 1895, 8-9; Similarly, Inspector Moylan stated in 1887 that the new hospital at the Manitoba Penitentiary was modelled on the one at the Kingston Penitentiary. Minutes, August 29, 1887.

54. For example, in the late 1880s new water closets and baths were installed there. Eleventh Annual Report of the Inspector of Penitentiaries for the Dominion of Canada for the Year Ended 30 June, 1886. (Canada: Sessional Papers, No. 4, 1887), 22.

55. Return to an Address of the House of Commons, dated 26th March, 1868; for the Report of the Prison Inspectors of the late Province of Canada on the Prisons of Nova Scotia and New Brunswick, 4; Sixth Annual Report of the Directors of Penitentiaries of the Dominion of Canada for the Year 1873. (Canada, Sessional Papers, No. 42, 1874), 15; Seventh Annual Report of the Directors of Penitentiaries of the Dominion of Canada for the year 1874. (Canada, Sessional Papers, No. 87, 1875), 67-68; First Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year 1875. (Canada, Sessional Papers, No. 14, 1876), 110; Second Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year 1876. (Canada, Sessional Papers, No. 15, 1877), 175.

56. First Annual Report of the Inspector of Penitentiaries...for the Year 1875, 125.

57. Eleventh Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1886, 51; Report of the Inspector for the Fiscal Year 1898-99, 19; Annual Report of the Inspector of Penitentiaries for the Fiscal Year 1902-03, (Canada, Sessional Papers, No. 34, 1904), xviii; Annual Report of the Superintendent of Penitentiaries for the Year Ended March 31, 1923. (Canada, Sessional Papers, No. 20, 1924), 10; Annual Report of the Superintendent of Penitentiaries for the Year Ended March 21, 1927. (Ottawa, 1928), 12.

58. Sixth Annual Report of the Directors of Penitentiaries...for the Year Ended 1873, 11; Seventh Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year Ended 30 June, 1882. (Canada, Sessional Papers, No. 29, 1883), 25; Thirteenth Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year Ended 30 June, 1887. (Canada, Sessional Papers, No. 11, 1888), xxix; Nineteenth Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1894, xx; Report of the Inspector of Penitentiaries for the Fiscal Year 1907-08, (Canada, Sessional Papers, No. 34, 1909), 21-22; Annual Report of the Superintendent of Penitentiaries of the Year Ended March 31, 1927, 13.

59. Seventh Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year Ended 30 June, 1882. (Canada, Sessional Papers, No. 29, 1883), 33-34; Ninth Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year Ended 30 June, 1884. (Canada: Sessional Papers, No. 15, 1885), 81; Thirteenth Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1888, xxiv-xxv, 87; Minutes, October 2, 1886, August 29, 1887, September 22, 1888.

60. Fourth Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year 1879. (Canada, Sessional Papers, No. 17, 1880), 191; Fifth Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1880, 118; Eighteenth Annual Report of the Inspector of Penitentiaries for the Year Ended 30 June, 1893. (Canada: Sessional Papers, No. 18, 1894), xviii-xix; Report of the Inspector for the Fiscal Year 1897-98. (Canada, Sessional Papers, No. 18, 1899), 39; Report of the Committee to Advise Upon the Revision of the Penitentiary Regulations and the Amendment of the Penitentiary Act. (Ottawa, 1921), 60.

61. Third Annual Report of the Directors of Penitentiaries of the Dominion of Canada for the Year 1870. (Canada, Sessional Papers, No. 60, 1871), 5; Fifth Annual Report of the Directors of Penitentiaries of the Dominion of Canada for the Year 1872. (Canada, Sessional Papers, No. 75, 1873), 16-17; Seventh Annual Report of the Directors of Penitentiaries...for the Year 1874, 67.

62. Report of the Inspector for the Fiscal Year 1898-99, 19, 49; Report of the Inspector for the Fiscal Year 1899-1900. (Canada, Sessional Papers, No. 34, 1901), 46.

63. Report of the Inspector for the Fiscal Year 1898-99, 13; Report of the Inspectors of Penitentiaries for the Fiscal Year 1902-03, 12.

64. Canada: House of Commons, Debates, 1884, 998 (March 20); Report of the Commissioners, 20-21; Canadian Magazine, November 1895, 14; Report of the Inspector for the Fiscal Year 1899-1900, 31.

65. Report of the Inspector for the Fiscal Year 1896-97. (Canada, Sessional Papers, No. 18, 1898), 9; Annual Report of the Inspector of Penitentiaries for the Fiscal Year 1900-01, 40; Annual Report of the Inspector of Penitentiaries for the Fiscal Year 1901-02. (Canada, Sessional Papers, No. 34, 1903), 34; Annual Report of the Inspector of Penitentiaries for the Fiscal Year 1902-03. (Canada, Sessional Papers, No. 34, 1904), xix.

66. Minutes, September 15, 1888, June 18, 1889, September 26, 1892; Seventeenth Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year Ended 30 June, 1892. (Canada, Sessional Papers, No. 18, 1893), 112; Eighteenth Annual Report of the Inspector of Pentientiaries of the Dominion of Canada for the Year Ended 30 June, 1893. (Canada, Sessional Papers, No. 18, 1894), xiii-xv.

67. Annual Report of the Inspector of Penitentiaries for the Fiscal Year 1906-07. (Canada, Sessional Papers, No. 34, 1908), 29-30.

68. Annual Report of the Inspectors of Penitentiaries for the Fiscal Year 1908-09. (Canada, Sessional Papers, No. 34, 1910), 27-28.

69. Eleventh Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1886, 47-48; Thomas McCrae, The Principles and Practices of Medicine, Tenth Edition. (New York and London: D. Appleton and Company, 1925), 338.

70. Penitentiary Regulations, 1870, 15; Ibid., 1888, 8; Ibid., 1899, 11.

71. Report of the Inspector for the Fiscal Year 1894-95. (Canada, Sessional Papers, No. 18, 1896), 29.

72. Eleventh Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1886, 22; Nineteenth Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1894, 9.

73. See the annual reports of the surgeon of the Kingston Penitentiary.

74. See the annual reports of the various penitentiary surgeons, for the years 1890-99.

75. For example, in 1891 Inspector Moylan noted in his Minute Book the case of a convict at Kingston who was consumptive and expected to die soon. His release would have been considered but he had no friends or relatives who would care for him. Minutes, May 8, 1891.

76. Sixteenth Annual Report of the Inspector of Penitentiaries for the Year Ended 30 June, 1891, 118; R.Y. Keers, Pulmonary Tuberculosis A Journey Down the Centuries. (London: Cassell Ltd., 1978), 22.

77. Canada: House of Commons, Debates, 1886, 893-95 (April 27); Ibid., 1886, 137-38 (March 13); Ibid., 1889, 218-21 (February 20).

78. Report of the Inspector for the Fiscal Year 1898-99, 50.

79. Keers, Pulmonary Tuberculosis, 58-64.

80. First Annual Report of the Board of Directors of Penitentiaries...for the Year 1868, 28.

81. Ninth Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1884, 41.

82. Annual Report of the Inspector of Penitentiaries for the Fiscal Year 1905-06. (Canada, Sessional Papers, No. 34, 1907), 35.

83. Annual Report of the Inspectors of Penitentiaries for the Fiscal Year 1909-1910. (Canada, Sessional Papers, No. 31, 1911), 37.

84. Report of the Inspector for the Fiscal Year 1898-99, 38.

85. Canada: House of Commons, Debates, 1906, 5397-98 (June 15).

86. McKelvey, American Prisons, 146, 181, 190-91, 259.

87. Charles Kyle Jolliffe, "An Examination of Medical Services at the Kingston Penitentairy, 1835-56", (M.A. thesis, Queen's University, 1983), 180-81.

88. Simon N. Verdun-Jones and Russell Smandych, "Catch-22 in the Nineteenth Century: The Evolution of Therapeutic Confinement in Canada, 1840-1900", Criminal Justice History, 2 (1981): 98-99.

89. Third Annual Report of the Board of Inspectors of Asylums, Prisons, etc., for the Year 1862. (Province of Canada, Sessional Papers, No. 66, 1863), "Criminal Lunatic Asylum, Rockwood", n.p.

90. P.A.C., MG26A, Papers of the Rt. Hon. Sir John Alexander Macdonald, Vol. 517, J.A. Macdonald to Sullivan, December 27, 1870; Catherine Sims, "An Institutional History of the Asylum for the Insane at Kingston, 1856-1885", (M.A. thesis, Queen's University, 1981), 37-40.

91. Sims, "An Institutional History", 39; Third Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year 1878. (Canada, Sessional Papers, No. 27, 1879), 10.

92. A plan for the new asylum is in the Map Collectior of the P.A.C., dated May 16, 1876. RG11M, 79003/42, D283, F89, Item 1531; Second Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year 1877. (Canada, Sessional Papers, No. 12, 1878), 17.

93. Third Annual Report of the Inspector of Penitentiaries...for the Year 1878, 10, 19; Fourth Annual Report of the Inspector of Penitentiaries...for the Year 1879, 20.

94. Fourth Annual Report of the Inspector of Penitentiaries...for the Year 1879, 20.

95. Fifth Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1880, 10; Sixth Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year Ended 30 June, 1881. (Canada, Sessional Papers, No. 12, 1882), 1; P.A.C., RG11M, 79003/42, D283, F29, Item 1531.

96. Sixth Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1881, 17-18.

97. Eleventh Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1886, 63-64.

98. Ibid., xii, 64; Statutes of Canada, 1883, Chap. 37, sec. 41.

99. Report of the Inspector for the Fiscal Year 1895-96. (Canada, Sessional Papers, No. 18, 1897), 11.

100. Seventh Annual Report of the Inspector of Penitentiaries...for the Year ended 30 June, 1882, 13.

101. For example, in the fiscal year ended June 30, 1899, the asylum received eight convicts from St. Vincent de Paul Penitentiary and two convicts from the Dorchester Penitentiary. In contrast, twenty-three convicts were admitted directly from the Kingston Penitentiary. Report of the Inspector for the Fiscal Year 1898-99, 42.

102. Thirteenth Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1888, xxv; Minutes, September 4, 1885.

103. Eleventh Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1888, xvi.

104. Minutes, June 15, 1886, December 6, 1886, December 12, 1887, April 24, 1888, February 5, 1889, April 28, 1890.

105. D. Hack Tuke, The Insane in the United States and Canada. (London: H.K. Lewis, 1885), 237-38.

106. Canada: House of Commons, Debates, 1891, 907-08 (June 16).

107. Ibid., 1892, 664 (March 30).

108. Sixteenth Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1891, xxii.

109. Report of the Commissioners, 19; Eighteenth Annual Report of the Inspector of Penitentiaries of the Dominion of Canada for the Year Ended 30 June, 1893. (Canada, Sessional Papers, No. 18, 1894), xii.

110. Nineteenth Annual Report of the Inspector of Penitentiaries...for the Year Ended 30 June, 1894, xvii.

111. Report of the Commissioners, 3.

112. Ibid., 19.

113. Annual Report of the Inspector of Penitentiaries for the Fiscal Year 1902-03. (Canada, Sessional Papers, No. 34, 1904), 5.

114. P.A.C., RG73 Vol. 95, File 3-1-6, Pt. 3, "Memorandum for the Deputy Minister", April 5, 1937, 8.

115. Statutes of Canada, 1895, Chap. 41, sec. 3.

116. Canada, House of Commons, Debates, 1895, 2166, 2175-79 (June 6); Some insane convicts had been sent to asylums in Ontario, but this practice was an unsatisfactory one. These convicts had to be pardoned. In one or two cases the insanity was very short-lived, allowing the prisoner to escape his punishment. Ibid., 2176.

117. See the annual reports of the Kingston Penitentiary surgeon for the years 1908-1915.

118. Report of the Royal Commission on Penitentiaries, 10-13.

119. Ibid., 10.

120. Ibid., 12.

121. Canada: House of Commons, Debates, 1915, 516-17 (March 1); Report of the Inspectors of Penitentiaries for the Fiscal Year Ended March 31, 1914. (Canada, Sessional Papers, No. 34, 1915), 7.

122. Report of the Royal Commission on Penitentiaries, 13.

123. Ibid., 12.

124. Canada: House of Commons, Debates, 1916, 2133-39 (March 24); It should be noted that due to his added duties Dr. Phelan was paid $2,400 annually, in contrast to the other penitentiary surgeons who received only $1,500 annually. Statutes of Canada, 1906, Chap. 38, "Schedule A".

125. P.A.C., RG73 Vol. 41, File 1-20-10, Pt. 6, "To his Royal Highness The Governor General in Council", January 25, 1915, 1-5.

126. See, e.g., Dr. Daniel Phelan, "The Prevention of Crime and Insanity", in Proceedings of the Annual Congress of the American Prison Association, 1911. (Indianapolis, 1911), 155-63.

127. P.A.C., RG73, Vol. 41, File 1-20-10, "To his Royal Highness the Governor General in Council", January 25, 1915, 4-5.

128. Annual Report of the Commissioners of Penitentiaries for the Fiscal Year Ended March 31, 1948. (Ottawa, 1949), 7-8.

129. P.A.C., RG73, Vol. 104, File 4-1-6, Pt. 1, "Memorandum for the Minister", July 6, 1914; P.A.C., RG73 Vol. 48, File 1-1-36 Pt. 2, "Memorandum for the Deputy Minister of Justice", April 5, 1937.

130. P.A.C., RG73, Vol. 48, File 1-1-36, Pt. 2, "Memorandum for the Deputy Minister of Justice", April 5, 1937, 11.

131. P.A.C., RG73 Vol. 104, File 4-1-6, Pt. 1, Chas. J. Doherty to W.J. Hanna, July 9, 1914.

132. Ibid., W.J. Hanna to Chas. J. Doherty, July 7, 1914, November 13, 1914.

133. Ibid., Chas J. Doherty to W.J. Hanna, February 5, 1915.

134. Ibid., S.A. Armstrong to Chas J. Doherty, February 24, 1915.

135. Ibid., Douglas Stewart to S.A. Armstrong, June 27, 1915.

136. Canada: House of Commons, Debates, 1916, 541 (February 3).

137. Report of the Royal Commission on Penitentiaries, 13-14.

138. Ibid., 14.

139. Ibid.

140. P.A.C., RG73 Vol. 41, File 1-20-10, Pt. 6, "Memorandum for the Deputy Minister", March 15, 1915, 12-13.

141. Report of the Inspectors of Penitentiaries for the Fiscal Year Ended March 31, 1916. (Canada, Sessional Papers, No. 34, 1917), 25.

Notes to Part Three

1. Report of the Committee Appointed by the Rt. Hon. C.J. Doherty, Minister of Justice to Advise Upon the Revision of the Penitentiary Regulations and the Amendment of the Penitentiary Act. (Ottawa, 1921), 9.

2. Ibid., 9-10.

3. Ibid., 10.

4. Ibid., 11-12.

5. John Kidman, The Canadian Prison: the Story of a Tragedy. (Toronto: Ryerson Press, 1947), 46.

6. Roger Graham, "Through the First World War", in J.M.S. Careless and R. Craig Brown, eds., Part One of the Canadians 1867-1967. (Toronto: Macmillan, 1968), 183-84; W.L. Morton, "The 1920s", in Ibid., 205-07.

7. Morton, "The 1920s", in Ibid., 207.

8. Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1943. (Ottawa, 1943), 41.

9. O.C.J. Withrow, Shackling the Transgressor. (Toronto: Thomas Nelson & Sons Limited, 1933), 1-2.

10. Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1933 and a General Report to December 1, 1933. (Ottawa, 1934), 39.

11. Report to Parliament by the Sub-Committee on the Penitentiary System in Canada. (Ottawa, 1977), 13.

12. Kidman, The Canadian Prison, 42.

13. Report to Parliament by the Sub-Committee, 13.

14. Kidman, The Canadian Prison, 44.

15. Library of the Ministry of Solicitor General, untitled paper by D.M. Ormond, in "Summary of the Proceedings of the First Canadian Penal Congress held in Montreal, Que. (Windsor Hotel) Thursday and Friday June 13 and 14 under the auspices of the Canadian Prisoners' Welfare Association", 10-12.

16. Kidman, The Canadian Prison, 43.

17. Withrow, Shackling the Transgressor, x; For a biography of Withrow, see Lindsay Scotton, "When the wages of sin were death", Toronto Star, October 1, 1983, A14.

18. Withrow, Shackling the Transgressor, 173.

19. Kidman, The Canadian Prison, 48-49.

20. Kenneth McNaught, "The 1930s", in Careless and Brown, Part One of the Canadians, 261-63.

21. A Summary and Analysis of Some Major Inquiries on Corrections - 1938 to 1977. (Ottawa: Department of the Solicitor General, 1977), 1-2; Report of the Royal Commission to Investigate the Penal System of Canada. (Ottawa, 1938), 354-61.

22. A Summary and Analysis of Some Major Inquiries on Corrections, 2-3.

23. Report of the Royal Commission to Investigate the Penal System of Canada, 28, 31, 44.

24. Ibid., 51; Report of General R.B. Gibson A Commissioner appointed under Order in Council P.C. 1313, regarding the Penitentiary System of Canada. (Ottawa, 1947), 4.

25. Report of the Committee Appointed...to Advise upon the Revision of the Penitentiary Regulations, 60. This report also called for the appointment of a medical director to supervise penitentiary medical services. Ibid., 29.

26. Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1924. (Canada, Sessional Papers, No. 20, 1925), 11; Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1927. (Ottawa, 1928), 12-13.

27. Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1924, 15-17.

28. Public Archives of Canada (hereafter cited as P.A.C.), RG73 Vol. 29, File 1-18-3, 1925 Warden's Convention, 91.

29. Withrow, Shackling the Transgressor, 13, 17-23, 93-98, 137-42, 152-58, 164-66, 175-80.

30. Ibid., 153-54.

31. P.A.C., RG73 Vol. 68, File 1-16-2, Pt. 1, Deputy Minister of Justice to the Deputy Minister, Department of Pensions and National Health, June 9, 1933.

32. Ibid., "Memorandum to the Deputy Minister of Justice" August 12, 1933. See the attached memorandum, titled "Medical Services Department of Justice Penitentiaries Branch", dated July 3, 1933, 1-2.

33. Ibid., 2-3.

34. Withrow, Shackling the Transgressor, 153.

35. P.A.C., RG73 Vol. 68, File 1-16-2, Pt. 1, "Medical Services Department of Justice Penitentiaries Branch", July 3, 1933, 3-4.

36. Ibid., "Memorandum for the Superintendent of Penitentiaries", September 13, 1933.

37. Report of the Royal Commission to Investigate the Penal System of Canada, 24.

38. Ibid., 13, 280.

39. Ibid., 294.

40. Ibid., 336.

41. Ibid., 280-81.

42. Ibid., 295.

43. Ibid., 120-21; The Archambault Royal Commission also considered whether penitentiary medical services whould be provided by an outside body, such as in American federal penitentiaries where the Department of Health had this responsibility. However, it left this consideration for the Prison Commission which, it hoped, would replace the existing office of the Superintendent of Penitentiaries. Ibid., 121.

44. Janice P. Dickin McGinnis, "The Impact of Epidemic Influenza: Canada, 1918-19", in S.E.D. Shortt, ed., Medicine in Canadian Society. (Montreal: McGill-Queen's University Press, 1981), 477, 452-53.

45. Ibid., 447-48; Harry F. Dowling, Fighting Infection: Conquests of the Twentieth Century. (Cambridge, Massachusetts: Harvard University Press, 1977), 195.

46. Report of the Inspectors of Penitentiaries for the Fiscal Year 1917-18. (Canada, Sessional Papers, No. 34, 1919), 16.

47. Dickin McGinnis, "The Impact of Epidemic Influenza", 449.

48. Report of the Superindendent of Penitentiaries for the Fiscal Year Ended March 31, 1919. (Canada, Sessional Papers, No. 34, 1920), 18-19.

49. Museum of the Staff Induction Centre, Correctional Service of Canada, Kingston, Ontario. Warden's Letter Book, Warden to W.S. Hughes, November 4, 1918.

50. Report of the Superintendent of Penitentiaries for the Fiscal Year ended March 31, 1919, 17.

51. Dickin McGinnis, "The Impact of Epidemic Influenza", 450-51.

52. Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1919, 17-22.

53. F.H. Leacy, ed., Historical Statistics of Canada, Second Edition (Ottawa: Statistics Canada, 1983), Series A1, #8.

54. Suzann Buckley and Janice Dickin McGinnis, "Venereal Disease and Public Health Reform in Canada", Canadian Historical Review, 63 (1982): 337-38.

55. J. Ian Casselman, "The Secret Plague" Venereal Disease in Early Twentieth Century Canada", (M.A. thesis, Queen's University, 1981), 143.

56. Buckley and Dickin McGinnis, "Venereal Disease", 338.

57. Ibid., 339-40.

58. Casselman, "The Secret Plague", 192.

59. Buckley and Dickin McGinnis, "Venereal Disease", 345-47.

60. Casselman, "The Secret Plague", 206, 237-40.

61. P.A.C., RG73 Vol. 69, File 1-16-10, Pt. 1, "Memorandum for the Honourable the Minister of Justice", February 19, 1924.

62. Annual Report of the Inspector of Penitentiaries for the Fiscal Year 1900-01. (Canada, Sessional Papers, No. 34, 1902), 48.

63. Ibid., 63.

64. Dowling, Fighting Infection, 92-93.

65. Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1922. (Canada, Sessional Papers, No. 20, 1923), 13; Now obsolete, the Wasserman test was a complement fixation test developed in 1906. It made possible the detection and treatment of millions of previously undiagnosed syphilitics. Syphilis a Synopsis. (Washington, D.C.: U.S. Department of Health, Education, and Welfare, Public Health Service Publication, No. 1660, 1968), 9, 98.

66. P.A.C., RG73 Vol. 69, File 1-16-10, Pt. 2, L. Robert to Warden, August 4, 1925.

67. Ibid., "Circular", May 19, 1925.

68. Ibid., "Circular", October 21, 1925.

69. Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1924, 16-17; P.A.C., RG73 Vol. 69, File 1-16-10, Pt. 1, "Memorandum for the Honourable the Minister of Justice", February 19, 1924.

70. P.A.C., RG73 Vol. 98, File 3-16-2, Pt. 1, "Memorandum for the Deputy Minister of Justice", May 21, 1929.

71. P.A.C., RG73 Vol. 107, File 4-15-5, Pt. 1, "Memorandum for the Honourable the Minister of Justice", December 2, 1932, 25-26; However, it was the opinion of Superintendent Ormond that venereal disease treatment was inadequate at the Dorchester Penitentiary, the Manitoba Penitentiary, and at the Saskatchewan Penitentairy. Another problem was that since the annual federal Government grant to the provinces for these treatments ceased at the end of the fiscal year 1931-32, this previously free service (worth at least $10,000 per year) now had to be paid for by the Department of Justice. P.A.C., RG73 Vol. 69, File 1-16-10, Pt. 2, "Memorandum for the Deputy Minister of Justice", December 22, 1932, 1-2.

72. Canada: House of Commons, Debates, 1934, 4612 (July 3).

73. Report of the Royal Commission to Investigate the Penal System of Canada, 121.

74. Buckley and Dickin McGinnis, "Venereal Disease", 354.

75. See, e.g., Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1933, 15. The surgeon of the Kingston Penitentiary stated here that there were no known cases where a diseased convict had infected others there.

76. Buckley and Dickin McGinnis, "Venereal Disease", 354.

77. P.A.C., RG73 Vol. 69, File 1-16-7, Pt. 1, "Memorandum to the Commissioner of Penitentiaries", July 28, 1948, 3; Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1943, 41.

78. Frank. L. Rector, Health and Medical Service in American Prisons and Reformatories. (New York: National Society of Penal Information, 1929), 153-54.

79. P.A.C., RG73 Vol. 30, File 1-18-4, Pt. 1, 1929 Warden's Convention, n.p.

80. Canada: House of Commons, Debates, 1922, 787-91 (April 22).

81. P.A.C., RG73 Vol. 30, File 1-18-4, 1929 Warden's Convention, 5.

82. P.A.C., RG73 Vol. 68, File 1-16-2, Pt. 1, "Memorandum for the Deputy Minister of Justice", December 10, 1935, 3.

83. Report of the Royal Commission to Investigate the Penal System of Canada, 270.

84. Ibid., 280-81.

85. Ibid., 294-95.

86. Withrow, Shackling the Transgressor, 18.

87. Report of the Royal Commission to Investigate the Penal System of Canada, 294.

88. Ibid., 328.

89. Ibid., 121.

90. P.A.C., RG73 Vol. 69, File 1-16-7, Pt. 1, W.S. Lawson to R.H. Wodehouse, May 9, 1944.

91. P.A.C., RG73 Vol. 95, File 3-1-6, Pt. 1, "Memorandum for the Deputy Minister of Justice", April 24, 1922, 1-2.

92. Ibid., "Memorandum for the Deputy Minister of Justice", April 9, 1924, 1-2.

93. P.A.C., RG73 Vol. 95, File 3-1-6, Pt. 3, "Memorandum for the Deputy Minister of Justice", April 5, 1937, 11-13.

94. P.A.C., RG73 Vol. 48, File 1-1-36, Pt. 1, Memorandum for the Honourable the Minister of Justice", June 13, 1923, 1.

95. For example, in 1935 Agnes Macphail complained at length in the House of Commons about the condition of the insane in the hospital of the St. Vincent de Paul Penitentairy. "One situation which I do feel should not be allowed to continue is that the sick and insane are in the same hospital separated only by the wall against which the heads of the beds stand. There seemed to be quite a number of really sick persons. As we went along at St. Vincent de Paul the warden indicated one man who had been operated on just the day before, and anyone who has gone through the sufferings of the day following a serious operation knows how difficult it is. Right near that man, out of his sight but just beyond the wall, was an insane man who was calling out loudly. The insane man could not help it, of course, but it seemed to me very difficult for the sick. I asked Warden Puize about it, and he said it always seemed difficult to get them moved off rapidly. First there was a period during which the officials were not sure whether or not the inmates were insane, and then it seemed quite a while from the time they became sure until the inmates where removed." Canada: House of Commons, Debates, 1935, 2426-27 (April 4).

96. Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1920. (Canada, Sessional Papers, No. 35, 1921), 13.

97. P.A.C., RG73 Vol. 48, File 1-1-36, Pt. 1. "Memorandum for the Honourable the Minister of Justice", January 26, 1928, 2.

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101. Ibid., "Memorandum for the Honourable the Minister of Justice", March 16, 1931, 1.

102. P.A.C., RG73 Vol. 30, File 1-18-4, 1929 Warden's Convention, 122.

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105. Report of the Royal Commission to Investigate the Penal System of Canada, 150-51.

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107. P.A.C., RG73 Vol. 95, File 3-1-6, Pt. 3, "Memorandum for the Deputy Minister of Justice", April 5, 1937, 13-14.

108. Report of the Royal Commission to Investigate the Penal System of Canada, 150.

109. Ibid., 153-54.

110. Canada: House of Commons, Debates, 1929, 3627 (June 12).

111. Ibid., 3625; Report of the Royal Commission to Investigate the Penal System of Canada, 154-55.

112. McNaught, "The 1930s", in Careless and Brown, eds., Part One of the Canadians, 255-56.

113. Report of the Royal Commission to Investigate the Penal System of Canada, 155-58.

114. Ibid., 156.

115. Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1922. (Canada, Sessional Papers, No. 20, 1923), 11.

116. P.A.C., RG73 Vol. 69, File 1-16-3, Pt. 1, see the replies to Inspector Hughes' circular of August 3, 1923, which asked about dental expenses at each institution since 1918.

117. Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1922, 11; Withrow claimed that at the British Columbia Penitentiary (according to its warden) the dental surgery consisted of a "common kitchen chair with an ordinary spittoon." Withrow, Shackling the Transgressor, 97.

118. P.A.C., RG73 Vol. 29, File 1-18-3, 1925 Warden's Convention, 91.

119. P.A.C., RG73 Vol. 69, File 1-16-3, Pt. 1, W.S. Hughes to the warden all penitentiaries, February 10, 1931.

120. Ibid., "Memorandum for the Honourable the Minister of Justice", February 1, 1923.

121. Blake McKelvey, American Prisons A History of Good Intentions. (Montclair, New Jersey: Patterson Smith Ltd, 1977), 294.

122. P.A.C., RG73 Vol. 69, File 1-16-3, Pt. 1. "Memorandum for the Honourable the Minister of Justice", February 1, 1923; Report of the Superintendent of Penitentiaries for the Fiscal Year Ended March 31, 1923. (Canada, Sessional Papers, No. 20, 1924), 5.

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129. Ibid., "Circular Re Cost of Dental Services", July 15, 1931; Report of the Superintendent of Penitentiaries for the Fiscal year Ended March 21, 1926. (Ottawa, 1927), 35-39.

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